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ABSTRACT

This report describes findings of a project to identify promising school-based practices in evaluation and intervention with children having attention deficit disorders (ADD). Introductory material explains the project's purposes and procedures. The next chapter provides an overview of the 26 promising practices identified through nominations by stakeholder consultants and visits to 10 sites. Nine of the 10 site-visited practices are described in some detail with the remaining 16 receiving a less comprehensive description. Contact information is provided for each practice. Additionally, instructional materials (both commercial and locally prepared) viewed as effective with students having ADD are identified. A section on implications of the project identifies common characteristics of the schools' promising practices including a high level of personnel commitment and competence, systematic development of social skills, strong administrative support, and a commitment to working with the child's family. A set of questions is offered to assist in the evaluation of any potential practice for use with this population. Questions address: impact on the student and family, practicality, specificity to ADD, focus on strengths as well as needs, interdisciplinary collaboration, family involvement, sensitivity to multicultural diversity, medical intervention, administrative support, and staff training. Appendices provide additional project detail and forms used in identifying and evaluating practices. (Contains 31 references.) (DB)

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PROMISING PRACTICES IN IDENTIFYING AND EDUCATING CHILDREN WITH ATTENTION DEFICIT DISORDER

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Education of Children with

Attention Deficit Disorder

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PROMISING PRACTICES IN IDENTIFYING AND EDUCATING CHILDREN WITH ATTENTION DEFICIT DISORDER

By

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Prepared For

Division of Innovation and Development
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ABSTRACT

The Federal Resource Center (FRC) at the University of Kentucky had as its mission to investigate school-based practices that show promise in meeting the needs of children and youth with attention deficit disorder (ADD) and their families. These practices include assessment strategies such as educationally relevant methods of identifying children with ADD. This report describes how districts developed and implemented strategies to evaluate children with ADD. Intervention practices were also sought that showed strong promise in serving these students. The project includes behavior management strategies, techniques to help these children organize their work, methods of delivering instruction, and training techniques. It also reports on materials that have been found useful in serving students with ADD.

A key to the success of the Federal Resource Center's ADD project has been the direct involvement of national consultants to guide the work, including teachers, school administrators, school psychologists, school social workers, school nurses, parents, physicians, and researchers. This group of consultants developed the criteria to determine whether a practice showed promise, devised a plan to locate school-based ADD practices across the country, and reviewed submitted practices. The consultants selected 26 practices that showed outstanding promise in serving students with ADD, 10 of which received site visits to obtain details regarding practice implementation.

This report obtains a description of the process used to complete the mission of the FRC, a discussion of the promising practices; a review of accompanying materials viewed as effective with students with ADD, and an analysis of what was learned from the FRC's two-year effort.

Introduction

This document was developed to summarize the work of the University of Kentucky's Federal Resource Center (FRC) project on attention deficit disorder (ADD). It is submitted as a final report to the Federal Office of Special Education Programs (OSEP) as part of this contract to conduct a special study on promising practices for children with ADD (Task 6). To remain consistent with the language of Federal legislation, the term ADD will be used throughout this report to refer to children and youth with attention deficit hyperactivity disorder or undifferentiated attention deficit disorder.

The FRC, with the support of identified stakeholder consultants, has identified field practices that show promise in serving children and youth with ADD. During the first year of the project (June 1991 through May 1992), a national search was conducted to locate identification and intervention practices that were meeting the needs of students with ADD. The FRC facilitated a review and selection process that identified 26 practices that show promise in meeting the educational needs of students with ADD and the service needs of their families. The second year of the project was dedicated to gaining additional information regarding practices, making site visits, and refining information obtained.

This report includes an introduction to the project's work, a description of the methodology used, a review of the 26 practices, a summary of the practices submitted by the FRC's consultants, materials that show promise in educating students with ADD, themes that emerged in promising school-based work, and a summary of the project.

Background

Children identified as having ADD are a heterogeneous group of youngsters who have serious problems in the areas of attention and impulse control. Developmentally inappropriate levels of overactivity frequently exist with this disorder. ADD is a prevalent childhood disorder and occurs with considerable variability in severity. It has a history of multiple labels including minimal brain damaged, hyperactive child syndrome, and attention deficit disorder with and without hyperactivity (Barkley, 1990).

Identification

Adequate school-based identification of ADD requires a multidisciplinary team involving the family, and school personnel, such as teachers, nurses, school psychologists, and social workers. Teachers play an important role in the evaluation and monitoring of children with ADD, because they are in a position to provide critical information on the child's classroom behavior and results of various educational interventions. Even though appropriate identification of students with ADD is necessary, school personnel often have little information available to them on how to approach this task.

Intervention

Another crucial aspect of working with children with ADD, once they are appropriately identified, is ensuring that their educational program is appropriate. Underachievement and low academic productivity are common with students with ADD. Many children with ADD are also noncompliant and display behavioral or social problems in the school setting. Students with ADD are at-risk for coexisting conditions such as specific learning disabilities and emotional and behavioral disorders. Because no two children with ADD are exactly alike, no single educational setting, practice, or plan can be uniformly recommended for these children. Many schools do not have information on how to plan and implement appropriate school-based interventions to set the stage for positive educational outcomes.

Mission

Therefore, the FRC was directed to collect, organize, synthesize, and report knowledge to enable educators and parents to respond to the needs of children and youth with ADD in the school environment. The focus was field-based practices in the areas of identification and intervention that show promise in responding to the needs of children, youth, and their families. It is expected that the practices described in this report will serve as an information base for school personnel and parents as they work and live with children with ADD.

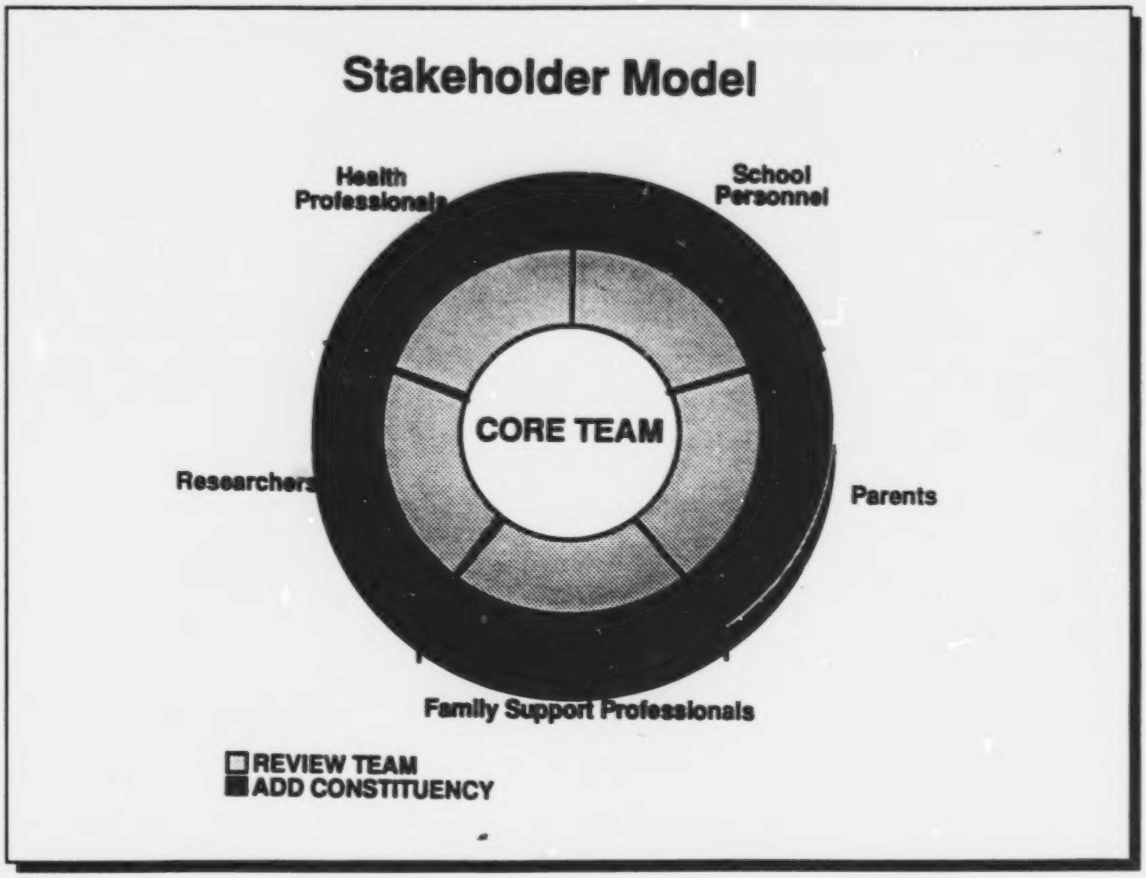
Procedure

The FRC has depended extensively on stakeholder involvement in the process of locating, reviewing, and selecting promising educational practices in identification and intervention for children with ADD. Stakeholders by definition have a vested interest in the objectives of the task. The stakeholder group, identified by the FRC, provided advice and guidance at every stage of the project.

A multiple level model for stakeholder involvement, as suggested by Pfeiffer, Goodstein and Nolan (1989) and Pascarella and Frohman (1989), was adopted by the FRC. The stakeholders represented five groups that are essential to the identification and intervention of children with ADD: school personnel, parents, healthcare professionals, family support professionals, and researchers. Not every stakeholder was able to participate in every decision, but all five perspectives were represented by the group. This model, as seen in Figure 1, has been adapted to

FIGURE 1

Representative Groups in the Stakeholder Model


Stakeholder Model
Health Professionals
School Personnel
CORE TEAM
Researchers
Parents
Family Support Professionals
☐ REVIEW TEAM
■ ADD CONSTITUENCY

a three-tier plan to include a core team, a review team, and finally the ADD constituency represented by those groups.

Individuals identified as stakeholder consultants for the FRC project had to have sufficient knowledge to contribute substantively to the process of identifying promising educational practices for identification and intervention for children with ADD. They had to be recognized leaders in the field and willing to make participation a priority. The stakeholder group had to represent a variety of geographical regions, include individuals knowledgeable in minority and cultural issues affecting ADD, and represent interests in a broad spectrum of age ranges from early childhood to secondary school age. In addition, stakeholder participants had to be directly involved at some level with children with ADD or their families.

The following section provides a description of the five critical groups included in the stakeholder process and a rationale for their involvement as consultants to guide the work of the FRC's ADD project.

Parents

Parents are important participants in identifying ADD as well as in developing and implementing educational strategies to promote successful school programming. As described by Stanley Klein (1993), parents are experts about their own children, and professionals need to learn from and use this expertise. Parents are essential members of school-based identification and treatment teams.

A parent's perspective on appropriate goals for a child in the context of the home, culture, and community is necessary. Thus it is crucial that parents be involved when promising practices in identification and intervention are explored. The two major groups focused on supporting parents of children with ADD are Children with Attention Deficit Disorder (CHADD) and Attention Deficit Disorder Association (ADDA). These two groups were contacted to get parent representation among the stakeholder consultants that would guide the work of the FRC.

School Personnel

Typical characteristics exhibited by children with ADD, such as inattention, overactivity and impulsivity, often lead to a myriad of problems in the classroom. These range from academic underachievement to social problems. Teachers, school psychologists, administrators, and other school personnel are important participants in the identification of youngsters who exhibit ADD characteristics as well as in the development and implementation of educational interventions to meet these children's needs. Since a broad range of problematic behaviors are exhibited at school, it is critical that school personnel be adequately represented when promising educational practices for ADD children are identified. The National Education Association (NEA) was contacted to locate teachers who were involved in improving the education of children with ADD. The Council for Administration of Special Education (CASE) and the National Association of School Psychologists (NASP), were also used to locate school representatives to participate as consultants on this project.

Family Support Professionals

Children with ADD often experience difficulty completing chores, following directions, getting along with siblings, and a wide range of other home-related activities. This difficulty frequently affects family dynamics. Therefore, family support in the form of parent training and counseling is often a recommended strategy for families who have children with ADD. When appropriate, these services can address many of the problems that children with ADD experience in their home, school, and community setting. Thus, it seems clear that professionals knowledgeable in family intervention participate in the work of reviewing promising practices for children with ADD and their families. To access individuals knowledgeable about ADD-related family intervention as stakeholder consultants, the National Association of Social Work (NASW), the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and the American Psychological Association (APA) were contacted to assist in locating representatives to serve as consultants on this project.

Health Professionals

Psychostimulant medication is by far the most common intervention for children with ADD. Research (Pelham, 1985; Douglas, Barr, O'Neill, and Britton, 1986, and Carlson and Bunner, 1993) has demonstrated short-term improvements in behavioral, academic, and social functioning of children being treated with stimulant medication. However, controversy persists regarding the side effects of the drugs, their behavior-modifying characteristics, long-term effects on performance, and monitoring of the medication by clinicians. School personnel are often in a crucial position to observe and report to the family and physician behavioral and academic performance differences associated with medication. Literature indicates that medication alone is not sufficient for effective intervention with children diagnosed as having ADD (DuPaul and Barkley, 1990; Cantwell, 1975; Conners and Wells, 1986; Pelham and Murphy, 1986; Swanson, Cantwell, Lerner, McBurnett and Hanna, 1991), even though it is an important component of the treatment program. Thus, it is important to include persons from the health professions on the committee to review promising practices with children diagnosed as having ADD. The National Association of School Nurses, the American Academy of Child and Adolescent Psychiatry, and the American Academy of Pediatrics were the three primary organizations contacted to obtain consultants who are among health professionals working with children and youth with ADD.

Researchers

As promising identification and intervention strategies are identified for children diagnosed with ADD, it is necessary to have individuals review them who are knowledgeable in terms of practice efficiency. Prominent researchers who have practical experience related to educational settings were sought out to be among the stakeholder consultants. They contribute substantively to the knowledge base at this time in both identification and intervention. Organizations such as the Professional Group for Attention Deficit and Related Disorders (PGARD) and the APA assisted in locating representative individuals.

Three groups of stakeholders were identified for the purpose of this project, namely, the core team, the review team, and the ADD constituency.

Core Team

This work group of 11 individuals representing the five areas noted in Figure 1 guided the FRC's efforts in the location evaluation and selection of promising practices in identification and intervention for children with ADD. This group met twice to provide input to the FRC and served as practice reviewers. The core team consisted of two parents of children with ADD, four individuals representing the public school perspective, two researchers, two healthcare professionals (one of whom is a parent of a child with ADD), and one family support professional.

Review Team

This team of 14 members reviewed the work of the core team and provided consultation and feedback to the core team. This group was directly involved in rating field practices submitted to the FRC. The review team consisted of one parent, five individuals representing the school perspective, four researchers (one of whom is a parent of a child with ADD), two healthcare professionals, and one family support professional.

ADD Constituency

This broad-based group represented interests in issues relevant to ADD in the five designated areas. Membership in this group was determined by national organizations associated with the five areas. Recommendations made by the organizations were used to obtain core and review stakeholder consultants and assist in locating individuals doing promising work with students with ADD.

See Appendix A for a complete list of the consultants used on this project.

The initial task of the core team, working in conjunction with the FRC staff, was to develop criteria for defining promising practices in the school-based component of assessment as well as in educational interventions.

Educational Identification

The FRC was interested in determining the types of practices, methods, and materials useful in assessing students with ADD at the school-based level. The following issues were pertinent: role of family members in the assessment process; relationship of school personnel in aiding the medical community in assessing the need for medication as well as assessing its effectiveness after it has been prescribed; organizational structure that facilitates effective school-based identification of children with ADD; and training needed by school personnel to conduct school-based identification with students. The core team determined that for a school-based identification practice to show promise it should:

- have a positive impact for the child with ADD or the family or both;
- have practical value or meaning in educationally intervening with the child with ADD or the family or both;
- have potential for replication at other sites with the expectation of similar results;
- acknowledge the benefits of early detection;
- address the major components of the disorder (inattention, impulsivity, and overactivity);
- focus on strengths as well as needs;
- show evidence of collaborative involvement with families and the community; and
- address the issues of cultural diversity.

Intervention

The FRC was also interested in intervention strategies school personnel have found helpful in working with students with ADD. The following issues were important when examining intervention strategies: types of material or technology used in working with students; ways in which the schools are involved in the use of medication as an intervention strategy for children with ADD; family involvement in the planning and implementation of interventions;

organizational support for effective intervention with students with ADD; and types of training being provided by schools to enable educators to more effectively meet the needs of children and youth with ADD and their families. It was determined by the core team that primary intervention strategies should:

- have a positive impact for the child with ADD or the family or both;
- have practical meaning or educational relevancy;
- have potential for replication at other sites with the expectation of similar results;
- enhance learning for the target population, whether it be teachers, children, families, or others;
- be designed to consider skill acquisition of desired behavior or academic material as well as maintenance and generalization;
- show evidence of collaborative involvement by families and the community; and
- focus on strengths as well as needs.

If a practice was submitted for review that related to medication issues, the core team indicated the practice should:

- provide baseline data on the child's behavior or academic performance or both to the medical personnel prior to their making the decision about medication;
- have a process for documenting the effects of medication on the child's academic performance or behavior or both; and
- include a system for observing and recording the side effects of medication on the child during the school day.

Once the criteria for selecting practices were established, the FRC staff and core team developed a two-step procedure to locate identification and intervention practices in use with students with ADD.

First, a one-page flier was created (see Appendix B). The flier asked if candidates had a practice that shows promise in working with children with ADD or their families or if they knew someone who did (indicating the name and address and returning the postage-paid form to the FRC). This flier was accompanied by a cover letter explaining the process.

Next, to generate a cadre of individuals who were thought to be doing good work with children with ADD, national organizations were contacted representing the five areas in the stakeholder model. These organizations were asked to provide the FRC with mailing labels of state representatives or contacts who could nominate individuals within each state who were doing promising work with children and youth with ADD and their families. In addition, presentations (requesting support in locating individuals working with children with ADD) were made to the executive boards of national organizations. Some national groups published descriptions of the project in their newsletters. One percent of public schools were randomly selected and contacted. As a result, over 15,000 fliers were distributed.

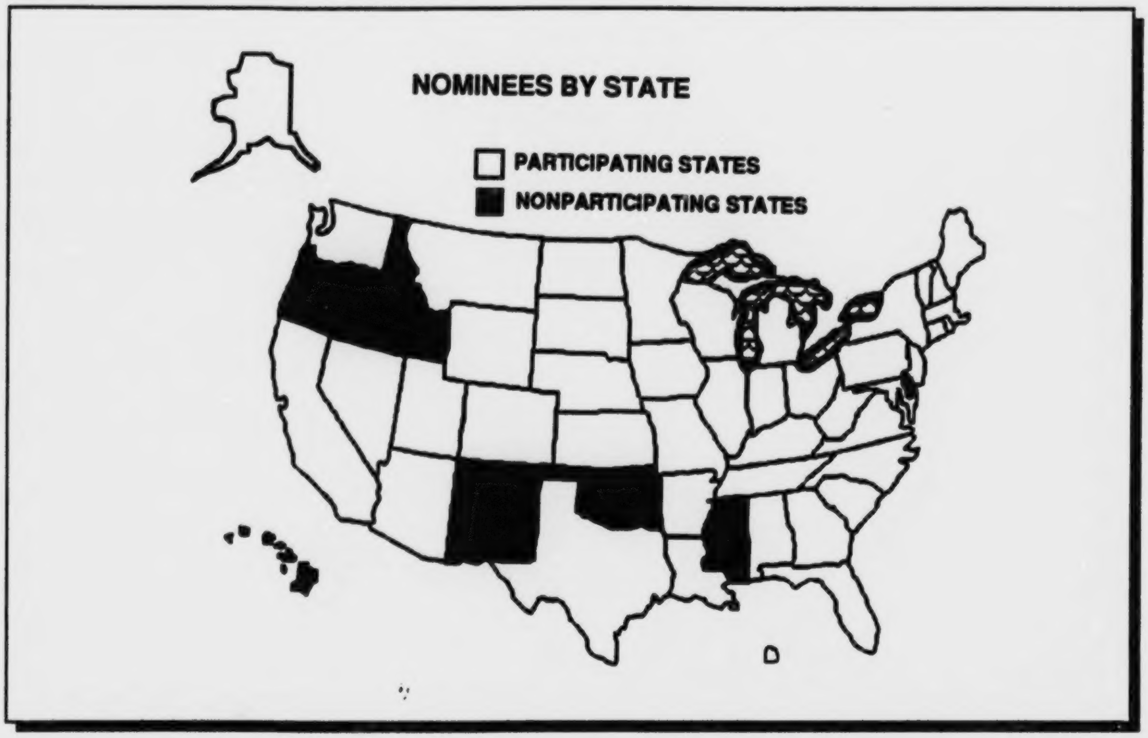
From this effort, 504 individuals were identified. These nominees were widely distributed geographically, representing 43 states (see Figure 2). Professionally, this cadre of nominees included teachers (39 percent), administrators (23 percent), school psychologists (13 percent), school nurses (7 percent), social workers (6 percent), school consultants (4 percent), school counselors (3 percent), and others (5 percent), including individuals such as university personnel, physicians, and private practitioners.

An application packet (see Appendix C) was sent to all nominees. The applicants were asked to provide a detailed summary of their practice, including the following:

- *Description of the practice.* In this description, applicants were asked to include a needs statement; goals and objectives; the how-to of implementing the practice; staffing, training and material requirements; and the kind of organizational or administrative support necessary to implement the practice.
- *Report on outcomes associated with the practice.* Respondents were asked to describe who or what changed as a result of the practice, as well as how one knew that change had occurred and the longevity of the change.

FIGURE 2

Geographical Distribution of Nominees



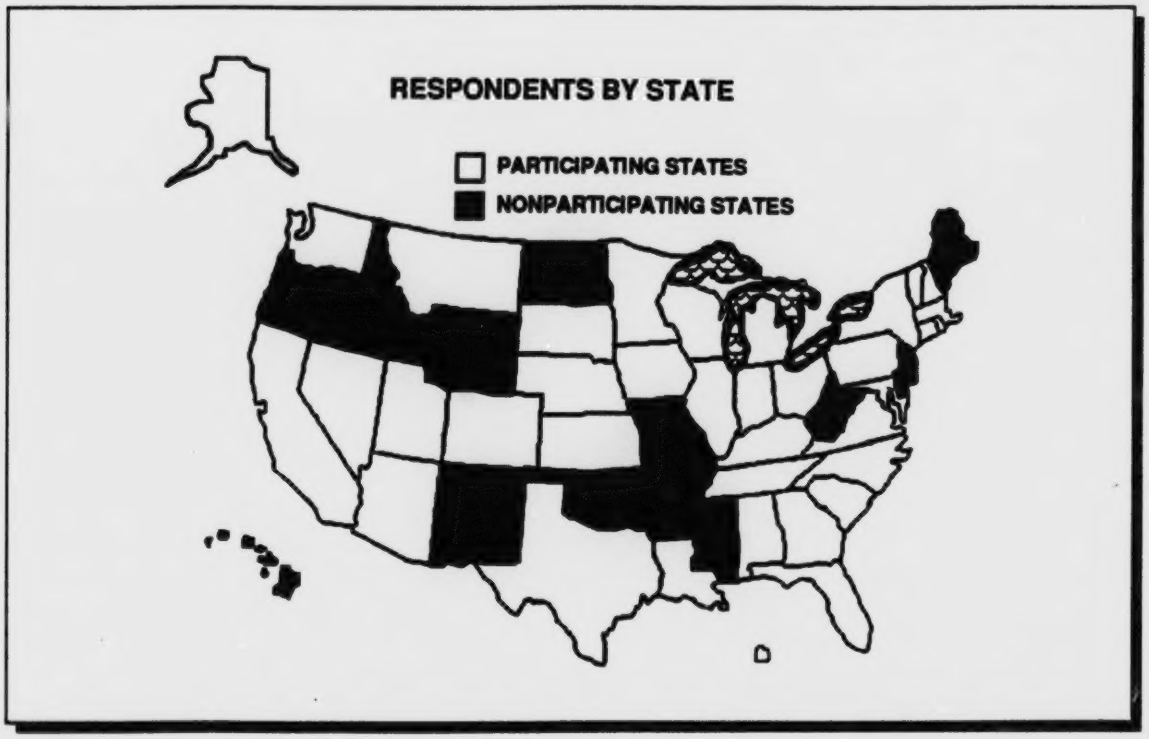
- *Description of replication requirements*. Nominees were asked to provide detail so that other professionals could adopt and replicate the practice with the expectation of similar results. They were to describe the setting, modifications needed to implement in other settings, and the human, physical, and financial resources needed to implement the practice.

One-hundred-forty-six practices from 36 states (see Figure 3) were submitted to the FRC for review. Sixty-nine percent were broadly described as intervention practices, and 31 percent were submitted as identification practices. A broad range of professionals authored these submissions, including teachers (33 percent), administrators (22 percent), school psychologists (21 percent), school consultants (6 percent), counselors (4 percent), social workers (4 percent), school nurses (4 percent), and others (6 percent), such as university personnel, physicians, and private practitioners.

20

FIGURE 3

Geographical Distribution of Respondents



Every consultant on the FRC project at the core and review team levels participated in reviewing the 146 practices. Eight groups consisting of three members each were created to serve as practice reviewers. Each group included one member of the educational community and two additional individuals representing two of the other four basic areas (research, parents, health, or family support). Each also included a core team consultant. Thus, each practice was reviewed by three independent reviewers representing three separate perspectives. The FRC randomly assigned practice descriptions to each of the eight groups. A check was then made to ensure that consultants did not review applications from their state of residence or where they had any interest or association. When that situation did occur, the practice application was reassigned to another group of reviewers.

All consultants who reviewed practices were trained via teleconference before they received any practice applications. Training was used to provide a consistent framework for rating the descriptions, implementing the scoring procedures, and increasing reliability. A sample practice description was developed specifically for the training process. Refer to Appendix D for copies of materials used to train reviewers.

Reviewers were instructed to read the application independently, list as many strengths and weaknesses as possible, and assign points for each section of the application: description, outcome, and replication. They were to assign a total score and a qualitative rating indicating whether the practice showed strong promise, some promise, or no promise.

Each consultant returned the evaluations to the FRC. The scores from the raters were correlated to determine inter-rater reliability. For each group of three reviewers, at least two raters had significant inter-rater reliability, suggesting that there was general agreement on the overall merits of the practice. Mean scores for each section of the application were calculated both for the quantitative scores (description, outcome, replication, and total score) and for the qualitative ratings (strong promise, 3; some promise, 2; and no promise, 1). This information was summarized and later used to assist the core team in deciding which practices showed promise for working with students with ADD.

The core team met to review the data and select practices to be included in this report. The consultants recommended that the practices be selected on the basis of a double-gating procedure. The first gate had to do with the qualitative ratings assigned to the practices by the stakeholder consultants who reviewed the practices.

To pass the first gate, an identification practice must have received qualitative ratings from at least two of the three reviewers indicating strong promise. Using that cutoff, approximately 30 percent (14 practices) of the identification practices were selected. To pass the first gate, an intervention practice must have received qualitative ratings where at least two of the reviewers indicated the practice showed strong or some promise. Using that cutoff, approximately 30 percent (32 practices) of the intervention practices were selected. Thus, the top 30 percent of identification and intervention practices passed the first gate.

To pass the second gate, the core team instructed FRC staff to re-review practices that had passed gate one and ensure that practices included consideration for

- geographical diversity;
- collaborative involvement;
- proven but also unique strategies;
- positive outcomes;
- potential for public school replication;
- inclusion of academic, social, and behavioral practices; and
- Representation of all school levels.

Three members of the FRC staff and one local review team member used the criteria above to review the practices that passed gate one. Nine practices primarily described as an identification practice and 17 primarily described as an intervention practice passed this second review. These practices will be described in detail in the Practices section of this document.

It was necessary to determine whether the promising practices were different from the practices submitted that showed little or no promise according to the identified relevant criteria. The written descriptions as submitted by the developers of the 26 practices that showed promise were compared to a randomly selected group of 26 practices that did not pass gates one or two of the selection process. The 52 practices were blindly rated by graduate-level school psychology students on seven key features noted as essential by the core stakeholder-consultants. The graduate students read the practice and simply noted either yes, the practice has this feature, or no, the practice does not include this feature.

As can be seen in Table 1, the practices that were rated as showing strong promise consistently included essential features absent in those practices that did not show promise. The table indicates the percent of practices that were rated as meeting the stated criterion. For example, 96 percent of the promising practices discussed how the practice resulted in positive outcomes for students or families, while only 52 percent of the practices with limited promise addressed this topic. This same pattern held regarding (a) description of replication, (b) the degree to which the three main features of ADD (inattention, impulsivity, and overactivity) were addressed in the practice, (c) family and community collaboration in the development and implementation of the practice, and (d) evidence that school administrators supported the practice. The only feature showing no significant difference between the manner in which promising and

TABLE 1

Comparison of Practices Rated as Having Limited and Strong Promise

Criteria	Limited Promise %	Strong Promise %	Chi Square p Value
Positive outcomes	52	96	.00039
Replication	32	88	.0005
Three major characteristics	32	60	.047
Collaborative involvement of families	60	88	.024
Collaborative involvement of community	16	56	.0032
School administration support	16	64	.00053
Cultural diversity	4	8	.53

nonpromising practices addressed a topic was that of cultural diversity. Only four percent of the practices that showed little promise and eight percent of the promising practices indicated how issues of diversity could be addressed in the work with students with ADD.

Essentially, this procedure of comparing the promising practices to a randomly selected group of practices that did not show strong promise was post hoc documentation of how they were indeed distinct.

PRACTICES

The heart of the FRC's project was the identification of school-based practices that show promise in serving children and youth with ADD and their families. Twenty-six practices were selected by the stakeholder consultants to demonstrate what schools and families can do to educate students with this disability. Ten practices received site visits by FRC staff. These 10 practices were selected from the 26 to represent diversity in location and type of practice. There should be no connotation that the 10 visited practices received higher ratings than the other 16 practices.

Nine of the 10 visited practices are described in considerable detail in this report, because the FRC staff had the opportunity to gain firsthand information regarding these practices. One practice selected for a site visit, an intervention practice from Baton Rouge, Louisiana, will not be featured in this report since it is not operational at this time. This district transported 76 children identified with ADD in the county to a specific elementary school that had been recognized for its outstanding student achievement. This school was characterized as serving families from low socioeconomic and diverse backgrounds. Teachers used multisensory, hands-on teaching techniques and emphasized the use of computers in the instructional process. Behaviors were managed through schoolwide contingency programs, and parents, teachers, and community service providers planned and participated in monthly meetings. School personnel and parents of children who participated in the program when it was operational were interviewed by FRC staff, who learned that this program indeed showed promise in serving children, with ADD. Parents were very enthusiastic about the positive outcomes for their children, and teachers reported how well it met the instructional and behavioral needs of the children. However, this practice was abandoned by the district because of financial difficulties. Administrators, parents, and teachers are working to rebuild the program. For more information, contact Lora Patureau at (504) 344-0084.

The nine promising practices are described in the section of this report called Site-Visited Practices. The remaining 16 practices are described in the section called Other Promising Practices.

Many of the consultants on the FRC's ADD project are engaged in school-based work that may be of interest to educators and parents. Following the descriptions of the 25 selected promising practices submitted by practitioners across the country is a section called Stakeholder Consultant Practices. This work was not reviewed or rated by project staff but is offered for additional practice ideas that may fill in some gaps in the delivery of services to students with ADD and their families.

Table 2 lists the titles of the 25 practices, the states they are from, the type of practice, and the page number where the summary is located. The stakeholder consultant practices are not included on this matrix.

All practices are reported in alphabetical order by state within their respective sections. At the end of each practice description, a contact person, a mailing address, and a telephone number are listed. Please contact these sites for more information regarding development, implementation, and evaluation of the practice.

TABLE 2

Practices Matrix

Practice Name	State	Page No.
Identification		
Elementary and Secondary Screening and Assessment Protocol	AK	24
Project for Attention-Related Disorders (PARD)	CA	75
Collaborative Evaluation Technique	CT	82
Guidelines for Serving Children with ADD Who Are Eligible Under Section 504	FL	42
Identification Procedures for Children with ADD	KY	57
Screening Procedure for ADD	NC	66
Identification and Medical Collaboration Plan	NC	70
Six-Step Education Program	WI	129
School-Based Collaborative Assessment	WI	137
Intervention		
Use of Paraprofessionals in Serving Students with ADD	CA	32
Comprehensive ADD Seminar	CO	80
Daily Checksheet	CT	87
Five-Level Point System	FL	91
Target Behavior of the Day	FL	94
Cooperative Consultation as an Instructional Model	FL	46
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SITE-VISITED PRACTICES

Elementary and Secondary
Screening and Assessment Protocol
Anchorage, Alaska

BACKGROUND

Anchorage Public Schools, population 46,000, developed an elementary and secondary assessment protocol for evaluated students suspected of having ADD. The goals of this protocol were to produce appropriate school-based assessments in an efficient manner; develop techniques and procedures appropriate for use in both elementary and secondary schools; generate data that are accurate and sufficient to differentiate learning disabilities, emotional or behavioral disturbance, and ADD; generate data that are helpful in designing classroom interventions; provide physicians and parents with sufficient and accurate data to assist in making medical diagnoses when appropriate; and provide an accurate and comprehensive baseline against which the behavioral effects of medical management of ADD could be evaluated.

DESCRIPTION

The school psychologists and school nurses who developed this practice reviewed current literature to determine the major issues surrounding the assessment of ADD. As a result of this review, a protocol was developed. The developers of this practice then coordinated inservice programs for the staff school psychologists, which included 16 hours of training on implementing the protocol. Also, a mandatory, one-day districtwide inservice was conducted to inform all regular and special education staff, including administrators, about the characteristics of students with ADD, classroom accommodations, and the new assessment protocol.

The assessment protocol was piloted, then revised at the end of one-year. The revision was based on input from school staff and parents as well as community service providers such as pediatricians. The revisions resulted in streamlining the protocol without sacrificing the quality and integrity of the assessment process. The revised process guides the psychologist and nurse through a series of data-based decisions that determine the amount of assessment to be conducted. The final protocol is, in essence, a decision tree that allows sufficient data to be collected so that appropriate recommendations for school-based interventions can be made; eligibility can be determined for special services under either the Individuals With Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973; and adequate behavioral data can be provided to physicians to assist them in providing medical services to the student.

The Anchorage public school system is committed to the concept of assistance teams and requires all ADD referrals to be served by the team for intervention development, implementation, and evaluation prior to formal referral. Included in Appendix E, Intervention Aids, is a copy of the Student Assistance Team Intervention Plan, which outlines the action steps taken by the assistance team in serving students. The data obtained from this pre-referral service are used as part of the assessment data.

The following is an outline of Anchorage Public School's Attentional Concerns Screening and Assessment Protocol. First, the elementary process will be described, followed by the secondary protocol.

Elementary

A. Educational History/Cumulative File Review
    1. Low marks for work completion? (Y/N)
    2. History of poor self-control, failing to accept responsibility? (Y/N)
    3. History of inattention to instructional tasks, poor independent work habits? (Y/N)
    4. History of delayed entry, retention, or referrals for Modified Primary, Slingerland or special education? (Y/N)
    5. Prior evaluations that suggest attentional problems? (Y/N)

B. Interventions Tried

1. Have interventions (e.g., behavior management, reducing environmental distractions, daily work completion/assignment sheets) been systematically and consistently tried? (Y/N)
2. What have been the results of interventions?

3. Have additional accommodations been attempted? (Y/N)

C. Results of Conners Teacher Rating Scale

1. Are the scaled scores 70 or higher on the Hyperactive, Inattentive/Passive (I/P) scales or Hyperactivity (H) Index? (Y/N)
2. Are the ratings reasonably consistent across teachers/settings? (Y/N)

D. Review of DSM-III-R Criteria

1. Does the student display at least 8 of the 14 DSM-III-R listed behaviors as described on the Teacher Ratings of Attention Concerns form?

If there is a history of poor school performance (section A) and interventions and reasonable accommodations have been tried unsuccessfully (section B), and Conners Teacher Rating Scale I/P Index and H Index are at or above 70 (section C), and 8 of 14 DSM-III-R conditions are present (section D), then consider a full evaluation with an attention focus (see below).

If there is no history of poor school performance (section A), consult with parents and teacher to determine what makes this year different.

If there have been no (or only insufficient) interventions (section B), consult with teacher or school assistance team or both to develop appropriate interventions.

If the Conners scale results are not sufficiently high (section C), consult with teacher and/or school assistance team to develop appropriate interventions.

If there is no apparent adverse impact academically, socially, or behaviorally, or on self-esteem, ascertain other reasons for requesting evaluation.

Full Attentional Concerns Evaluation

A. Document intellectual ability. Can use prior individual tests, Cognitive Abilities Test, or Gifted Program screening results.

B. Document academic achievement. Use one screening test (e.g., WJ-R).

C. Document behaviors. Use the Child Behavior Checklist and Concerns Rating Scales to document emotional or behavioral concerns at school and home. These are to be obtained from parents and as many teachers as possible.

D. Obtain a health history. Work through school nurse to obtain this information.

E. *It is necessary to rule out learning disabilities, serious emotional disturbance, and other health impairments.*

Secondary

A. Educational History/Cumulative File Review

   1. If the student attended elementary school in Anchorage, have there been low marks for work completion, self-control, acceptance of responsibility, independent work skills, attentive listening, etc.? (Y/N)

   2. Is there a history of delayed entry, retention, or referrals for alternative or special education? (Y/N)

   3. Have prior evaluations suggested attentional problems? (Y/N)

B. Interventions Tried

   1. Have interventions (e.g., preferential seating and weekly work assignment completion and sheets) been systematically and consistently tried? (Y/N)

   2. What have been the results of interventions?

   3. Have additional accommodations been attempted? (Y/N)

C. Parent Meeting

   1. Family information. Were ADD symptoms present prior to age 7? (Y/N)

   2. Results of the Conners Parent Rating Scale. Are the scores 70 or higher on the Impulsive/Hyperactive Scale or Hyperactivity Index? (Y/N)

   3. Parents approve of distributing checklist to teachers? (Y/N)

D. Teacher Input

1. Are Conners scores consistently 70 or higher on the Hyperactivity, Inattentive/Passive Index? (Y/N)

2. Using the Teacher Evaluation of Student Performance (TESP), do most behaviors characteristic of ADD on items 6 to 13 receive "lowest 1 in class" ratings by most teachers who circle a number? (Y/N)

A full evaluation with an attention focus (see below) should be considered if there is a history of poor school performance (section A), and interventions and reasonable accommodations have been tried but not successfully (section B); if ADD symptoms were present prior to age 7; if Parent Conners UH or H Index is at or above 70 (section C), or if Teacher Conners H, VP, or H indexes are consistently above 70 and characteristic behaviors are present (section D). Otherwise, write a case note to document screening.

If there is no history of poor school performance (section A), consult with parents or teachers or both to determine what makes this year different.

If there have been no (or only insufficient) interventions (section B), consult with counselor or teachers or both to develop appropriate interventions.

If the Conners results are not sufficiently high (sections C and D), consult with counselor or teachers or both about possible accommodations and interventions.

If the characteristic behaviors are not present (section C and D), consult to develop appropriate interventions.

If parents do not approve of distributing checklist to teachers (section C), consult as needed.

If there is no apparent adverse impact academically, socially, behaviorally, or on self-esteem, ascertain other reasons for requesting evaluation.

Full Attentional Concerns Evaluation

A. Receive referral and parent permission.

B. Obtain a health history. Document whether ADD symptoms were present prior to age 7. Work through school nurse to obtain this information.

C. Conduct classroom observations as needed. Seek nurse's assistance with observations.

D. Conduct a student interview.

E. It may be necessary to rule out a learning disability or serious emotional disturbance.

   1. Conduct assessment similar to that for a child with learning disabilities, which includes intelligence and achievement test if any item 1, 2, or 3 on the TESP receives "lower 4" ratings by most teachers or cumulative review suggests serious academic problems. It is seldom necessary to administer individual intelligence and achievement tests when serious academic problems are not suspected. Group test results may yield valuable information.

   2. Conduct assessment similar to that for a child with behavioral or emotional problems, which includes Child Behavior Checklists if TESP items 19, 20 or 21 are given "lowest 1" ratings by most teachers OR Bizarre Behavior is documented on page 2 of the TESP, OR if parent contact reveals possible serious emotional disturbance.

F. Write assessment report.

Previous Diagnosis of ADD

If there has been a previous medical diagnosis of ADD, then determine the student's present level of educational functioning (PLEF) by consulting with teachers.

If there are continuing serious academic and behavior problems, use the results as a basis of evaluation to help the assistance team develop a Section 504 plan. It is not necessary to proceed through the ADD screening process for previously diagnosed students.

If, however, the testing does not support continuing serious academic and behavior problems, consult with counselor or teachers or both to develop possible (non-504) interventions.

In some cases, it may be necessary to gather more information for previously diagnosed students when information from the PLEF is incomplete or inconclusive.

It should be noted that the school psychology staff in Anchorage Public Schools does not attempt to diagnose ADD medically. However, on the basis of the data collected, the staff determines whether there is an educationally significant attention problem that requires specific accommodations. Parents are included in this process of assessment and sometimes are encouraged to share the school data with the child's physician. However, under no circumstances are parents led to believe they must take their child to a physician for an ADD evaluation, or that medicine is required for a successful school experience. Regardless of whether a medical management plan is agreed on between the parents and the physician, the child's learning or behavior problems or both still require school-based interventions. In other words, a medical diagnosis is not necessary in this system to institute specific accommodations.

OUTCOMES

The response from teachers, administrators, parents, physicians, and school psychologists to the revised assessment protocol has been enthusiastic. The process is viewed as having numerous benefits: It is a time-efficient way to assess students; it generates appropriate information to address the student's academic, behavioral, and social/emotional needs; it allows for close communication between parents and school personnel; it generates data that are useful in designing interventions for students; it generates data to determine eligibility for special education services; it generates data useful to physicians in medical evaluation of students; and it provides baseline data against which to judge relative effects of medication.

REPLICATION

A school system attempting to replicate this practice should review the screening and assessment protocol carefully and make modifications as needed. For example, this system relies heavily on the school psychologist to manage the process; however, other school personnel could do the managing. Anchorage developed several forms to facilitate the screening and assessment process and used commercially available materials. These may be obtained by contacting the Anchorage school system.

Training was also an essential ingredient of this practice. All school personnel were required to attend a one-day inservice to raise awareness about ADD and be informed of the assessment protocol. In addition, psychologists received 16 hours of training to equip them with the skills needed to conduct the process.

Administration at all levels supported implementation of this new protocol. They provided release time for training, attended inservice sessions, and endorsed this method of serving students with ADD.

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Use of Paraprofessionals in Serving Students with ADD
Irvine, California

BACKGROUND

In 1989-90 El Toro Marine Elementary School, which has about 600 students, implemented a comprehensive program to serve children with ADD. The school serves an inner-city population, almost one-third of which has limited English proficiency. The teacher-student ratio in regular education classrooms is 30 to 1.

When the Irvine Unified School District (IUSD), which serves 25,000 students, recognized that the educational needs of some of its students with ADD were not being met, it arranged with the University of California, Irvine, Child Development Center (UCI-CDC) to identify these students at the elementary level and to send the most seriously affected to the model program at a re-entry program located at the El Toro school. Subsequently, CDC and IUSD staff decided to expand the program to treat students identified with ADD throughout the district at El Toro instead of transferring them to the UCI-CDC model school. Now UCI is expanding to other schools throughout the district so that students can remain in their home schools. This report describes how the UCI-IUSD school-based intervention program works.

DESCRIPTION

The UCI-IUSD model is based on direct intervention with ADD students in the regular classroom using paraprofessionals trained as behavioral specialists as interim classroom aides. These paraprofessionals are considered essential to provide the frequent positive feedback required to shape the ADD student's behavior in the regular classroom.

Many children with ADD have seriously disturbed relations with others that lead to disruptive classroom behavior. The goal of intervention is to modify this behavior so that the child can remain in the regular classroom and learn. The UCI-IUSD model uses a twofold approach: implementing an in-class reinforcement program designed to increase the frequency of acceptable behaviors in the classroom and on the playground, and shaping appropriate social interactions in intensive "social skills training" small-group sessions for one and one-half hours twice weekly.

The regular classroom teacher initially identifies students to be assessed for ADD using a child study team comprising the school psychologist, the special education teacher, and the referring teacher. Out of a classroom of up to 30 students, a maximum of three ADD students are targeted for intervention at any one time by the team. The youngest and most severely affected students have priority for intervention.

Before the team meets, the teacher summarizes various students' specific problem behaviors, desired alternative behaviors, previous attempts at modification in the classroom and elsewhere, any special health considerations, and reinforcement mechanisms previously used. Then the psychologist observes the students in the classroom.

When the study team meets, it selects the students for participation in the program, reviews the selected students' previous treatment history, designs a behavioral intervention strategy for the classroom for each student with ADD, and develops criteria for evaluating the success of the intervention (or the level of success that requires moving to the next level of intervention).

If the student with ADD fails to progress according to the criteria established by the team, a trained paraprofessional is assigned to the classroom for approximately 12 weeks. This paraprofessional works as a classroom aide in the regular classroom. The child study teams designs a detailed behavioral intervention to be implemented by the teacher and the paraprofessional. A daily reward system is built into each child's program and provided at school by designated personnel.

The paraprofessional, along with another staff member such as the school psychologist, also meets with up to six students at a time outside class in twice-weekly social skills training sessions. This allows the social skills component of the program to be implemented along with a detailed point system and student feedback.

The goal is to develop an effective program that the regular teacher can handle alone, as the students with ADD begin to require less individualized and intensive treatment. After the paraprofessional's participation in the classroom is over (typically 12 weeks), the regular teacher takes over the program, continuing to receive support from the school psychologist or the resource special program teacher.

For each successive teacher, the child study team designs an intervention plan for each student with ADD. Before a child moves from grade to grade, a representative of the child study team meets with the new teacher.

Team Responsibilities

A consulting psychologist, in this case a UCI professor, is responsible for providing inservice training for district administrators to gain their support for the program; training instructors for the courses in the paraprofessional behavioral specialist certificate program; providing inservice training for district staff; helping to develop the school-based reinforcement program; and evaluating the effectiveness of the program.

The school principal is responsible for providing administrative support and adequate resources to implement the program: funding the paraprofessional's position; providing a room for the twice-weekly small-group "social skills" meetings; and identifying school staff who will implement a school-based reinforcement program.

The school district's ADD program specialist provides training, with assistance from the consulting psychologist, to all members of the child study team on identifying and assessing students with ADD; supervising school psychologists in developing behavioral interventions in the classroom; and monitoring the school-based reinforcement program.

The school psychologist leads the child study team and is primarily responsible for identifying students with ADD and coordinating the development and implementation of their individualized programs in the regular classroom. The school psychologist may also participate in the small-group meetings.

The regular teacher must agree to participate in team meetings twice a month, carry out the behavioral program when the paraprofessional is absent, take over the behavioral intervention at the end of the 12 weeks, write a transition plan for each student with ADD, and meet with the ADD student's teacher for the forthcoming year to discuss the case.

The paraprofessional is responsible for implementing the behavioral intervention designed by the child study team and for conducting small-group meetings twice weekly. The paraprofessional also attends all child study team meetings for his or her students and keeps records of student progress.

Paraprofessional Training

Paraprofessionals become certified by completing a three-term training program provided by the university or community college and taught by school district staff. The behavioral specialist certificate program is a regularly offered training program and is recognized by IUSD as appropriate training for the paraprofessional position. The first quarter consists of coursework focused on behavioral intervention. In the second quarter, paraprofessional trainees gain field experience for 10 hours a week. They are assigned to district staff with expertise in the development and implementation of classroom behavioral interventions and observe and participate in parts of the program with elementary school children. In the third quarter, the paraprofessional trainees work as behavioral specialists under the supervision of district staff. Those who successfully complete the course are certified as paraprofessionals eligible for employment by the school district.

Child Identification Procedures

The consulting psychologist and the district's ADD program specialist teach the school psychologist how to identify and assess children with ADD. The IUSD program uses a two-tiered assessment process recommended by the Professional Group for Attention and Related Disorders (PGARD).

The first tier of the identification process consists of gathering and analyzing home and community information, school information, medical information, and behavior rating scales. If the Tier 1 evaluation confirms that the child has ADD, the evaluation proceeds to Tier 2 to determine whether the school manifestations are severe enough to impair the child's educational performance. Tier 2 evaluations consist of observations in the classroom to compare the target child's behavior with the behavior of peers, measures of the child's academic productivity, screening for other disabilities, and implementation and evaluation of trial interventions. If Tier 1 and 2 evaluations indicate that an attention deficit disorder is significantly interfering with the child's schooling, the student is eligible to participate in the program.

Child Study Team

The school psychologist, supervised by the consulting psychologist and the school district administrator, leads the child study team, which designs behavioral interventions for targeted children with ADD and monitors student progress. The school psychologist also helps prepare the regular classroom teacher to take over intervention at the end of the behavioral specialist's 12 weeks in the classroom. The psychologist reviews each student's progress and leads the discussion of strategies for teaching the child with ADD. A district administrator monitors the activities of the child study team, and the consulting psychologist advises the school district's ADD program specialist and the child study team as needed.

Reinforcement Plan

In contrast to many programs in which families take the responsibility for rewarding children at home for meeting school behavior and academic goals, the IUSD program has a reinforcement center at school, located away from the classrooms, for use at the end of the day. A designated school staff member implements this portion of the program. The principal has assigned the counselor to provide this service at El Toro. This individual completes reinforcement inventories on all children in the program, ensures that reinforcing activities are provided to reflect each child's choices, and varies available reinforcers to enhance the effects of the program. The last 20 minutes of each school day are used to implement this school-based reward system.

Social Skills Training

The small-group social skills training sessions, developed at UCI, target collateral behaviors — such as leaving one's seat without permission, making noises and talking out during quiet time, and behaving aggressively toward peers and teachers — that interfere with academic tasks. Once these collateral behaviors are controlled, other behaviors directly related to academic tasks can be targeted for intervention.

The small-group sessions use modeling and rehearsal of appropriate behavior, role-playing, and continuous reinforcement to help the children learn how to respond appropriately to the teacher's and the paraprofessional's verbal and visual cues in the classroom. A modified version of a point system developed by Dr. William Pelham is used to shape appropriate behavior during small-group training. Positive behaviors earn points for students and negative behaviors cause a deduction of points.

In the *good sportsmanship* module of the social skills training program, students learn how to follow the rules of a game or activity; stick with the game or activity; share equipment and take turns; accept the consequences and lose gracefully; cheer for peers; congratulate others on their efforts; invite onlookers to participate; cooperate; and consider others' suggestions.

In the module on *ignoring a provocation or disruption*, students learn how to interrupt the escalation of a minor provocation to a conflict and to remain on task despite the disruptive behavior of others.

In the *assertion training* module, students learn to discriminate between passive and submissive, and between aggressive and assertive, and they learn to link probable consequences with each behavior style. They learn to exhibit assertive (instead of aggressive) responses to various problem situations. As part of the training, the paraprofessional explains how specific behaviors — such as eye contact, body language, tone and volume of voice, length of verbalization, and politeness — can be located along a continuum between the extremes of passivity and aggressiveness. The paraprofessional may briefly demonstrate inappropriate styles of behavior to help the children learn how to differentiate among them, but the paraprofessional concentrates on modeling an assertive style that communicates self-respect and respect for others. The specialist uses stuffed animal characters to exemplify the three behavioral styles: passive-submissive (Wimpy Wally), assertive (Cool Craig), and angry-aggressive (Mean Max). Children who are unable to grasp the abstract qualities of the styles can readily understand the concepts of using "Cool Craig voice" and handling a given situation the way Cool Craig would.

In the *acceptance training module*, students learn appropriate reactions to frustration: staying calm, getting along, continuing to follow directions, and verbalizing compliance ("Okay," "Sure").

The students also learn to differentiate among the basic emotions (fear, happiness, anger, sadness, etc.) and to understand how these feelings bring on certain behavior or how certain behavior brings on these feelings. The paraprofessional discusses inappropriate emotional responses and teaches appropriate ones.

Daily charting is used as a tool for setting goals and evaluating overall behavior during skills training. The paraprofessional reviews each child's accumulation of points daily with the child and classifies the child's performance on the basis of percentage of points earned.

Specific skills are selected each day from the menu for the module being taught. The paraprofessional first presents the skills didactically, then models them, and subsequently prompts, shapes, and rehearses the students in using them. Students can earn extra points for exhibiting the skills in board games or team sports. An important side benefit is the social competency students gain from learning the rules and getting practice in a variety of sports and recreational activities.

Token System

The paraprofessional has the primary responsibility for implementing the reward system in the classroom. Children can earn up to five points per 15-minute interval for these specific behaviors: (1) following the quiet rules (one point per interval with no unauthorized verbalizations); (2) following seat rules (one point per interval in which the child remains seated in the chair or on the rug as required); (3) maintaining appropriate relations with others (one point per interval in which the child engages in no verbal or nonverbal provocation, cursing, aggression, or destruction of property; (4) completing work or attending to discussion (one point per interval in which the child completes all the work specified by the teacher or, if no measurable work is required, for attending to the activity in progress); and (5) completing work neatly (one point per interval in which the child completes three-quarters of class assignments neatly or, during class discussions, when the child's behavior is task related). In addition, students receive at least three verbal prompts per interval. They are then assigned a "level" in accordance with the percentage of total possible points. Level 1 is up to 79 percent (signified by the color blue), level 2 is 80 to 89 percent (yellow), and level 3 is 90 percent or higher (red).

The program's goal is to systematically increase the intervals for earning points and reduce the verbal prompts necessary to maintain appropriate behavior, so that the teacher can eventually take over managing the child without assistance from the paraprofessional.

Once a child has averaged at least 90 percent for 10 days, he or she is promoted to level 2, where the intervals are increased to 30 minutes (the prompts remain at no more than three for that period). After maintaining an average of 90 percent for another 10 days, the child may progress to level 3, where the intervals are one hour (and the prompts continue at no more than three for that period).

Follow-up

Once the student has reached level 3, responsibility for implementing the behavioral program is transferred to the classroom teacher. The child study team writes out a transition plan detailing the procedures that the student understands and the teacher can use for intervention. When the student goes to a new classroom, the child study team can modify this plan in consultation with the new teacher's program.

Outcomes

At El Toro Marine Elementary School, testing indicated that all students who both received the social skills training in the small-group sessions and had the benefit of the paraprofessional's presence in the regular classroom improved during the year: their disruptive behavior dropped by more than 50 percent. In contrast, among members of a group who participated only in the social skills sessions, disruptive behavior dropped by less than 20 percent. And among members of a control group who received no special help, disruptive behavior increased by 15 percent.

Furthermore, interviews with teachers during the 1991-92 school year, when the students were no longer in a special intervention program, revealed that one student who had been sent to the principal's office two to four times a week before participating in the intervention program had been referred to the principal only twice in the previous 5-months. The other students were still in regular classrooms where they had been placed in 1991-92 and, despite some minor problems, were rated as performing adequately or better in their classes.

Replication

During the 1992-93 school year the program was successfully replicated in other schools in a neighboring school district. UCI worked with that school district and trained all the paraprofessionals. The participation of teachers, counselors, school psychologists, and principals is assumed to part of their normal activities. Thus, the cost of the project appears to be confined mainly to the salaries of the outside consultant and the paraprofessional behavior specialists.

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Guidelines for Serving Children With ADD
Who Are Eligible Under Section 504
Fort Lauderdale, Florida

BACKGROUND

Broward County Public Schools, population 200,000, developed a plan for serving children whose attentional deficits were interfering with their ability to learn. The Broward County system has a history of using child study and intervention assistance teams, and so this model was used in serving students suspected of having ADD. This process often culminates in a referral for services under Section 504 of the Rehabilitation Act of 1973, which is the focus of this report.

DESCRIPTION

The Broward County school system is a fast-growing, urban system that serves a highly diverse population. The schools are large with an average enrollment of 800 students at the elementary level. Some elementary schools have enrollments of more than 1,400 children. The middle and high schools are, of course, even larger.

To manage referral problems for any at-risk child, the school system developed a layered screening process, which begins with each school designating a contact person to handle all requests for assistance for students. This school-based contact person reviews each request and channels it to the appropriate support professional, such as the school psychologist, counselor, or social worker.

The support professional reviews the records, makes observations, collects pertinent data, and consults with the child's teacher to develop a plan of action. This plan may include additional classroom interventions, referral to an outside service agency, or referral to the building-based assistance team.

Once the assistance team receives the referral, it reviews the previous information and then, with the family, determines whether the student meets the Section 504 classification as a qualified individual with disabilities. If a child is considered a candidate for Section 504 services, the parents, teachers, and support professionals collaborate in planning accommodation strategies that meet the child's needs and develop an accommodation plan. This plan specifically asks the team to address what modifications need to be made, if any, in the physical arrangement of the classroom, lesson presentation, work assignments, test-taking methods, helping the student get organized, managing the child's behavior, and addressing medication needs. Other considerations are addressed, such as whether the bus driver needs support in managing the child and whether the child's teacher needs information about ADD.

Once the accommodation plan is developed, a school-based case manager is assigned to the child. This person's responsibility is to complete the Section 504 record. This record indicates the specific areas of difficulty for the child, the accommodations to be made, the date to start each accommodation, the person responsible for implementing each accommodation, and the outcome. It is the case manager's job to monitor the plan, set timelines for implementing and evaluating the accommodations, and determine outcomes. Parents receive copies of the accommodation plan and the 504 record along with a formal notice of their rights under Section 504. Students eligible for services under Section 504 are entitled to periodic re-evaluations (at least every 3-years, unless there is a need for more frequent review).

If the accommodations described on the Section 504 record prove ineffective, the case is resubmitted to the school-based assistance team. The team, along with the family, has two choices at this point. The first is whether to redesign and modify the accommodations on the Section 504 record. If this decision is made, the student continues services with monitoring by the case manager. The second option available to the committee is to refer the case to special education services for a psychoeducational evaluation. The case is then handled by a exceptional student evaluation specialist and moves into the purview of special education.

Broward County has taken a clear position that most students with ADD can be educated in the regular program with the help of appropriate interventions. School system officials indicate that Section 504 services should not be confused with one more aspect of special education and that students suspected of having attentional deficits should not be evaluated for special education until an appropriate accommodation plan has been implemented and evaluated.

The Broward County public school system has developed a range of material to describe its guidelines for the implementation of Section 504. Included are a handbook outlining the process, a series of forms that enables schools in the system to comply with the guidelines, and a videotape that illustrates the process. These materials have been used systemwide to train school staff on the procedures.

Key to the success of the Broward County program has been the district's commitment to fund a professional staff position to coordinate efforts to serve children who are eligible for services under Section 504. This individual has collaborated with parents and community experts to develop procedures, products, and training.

OUTCOMES

This model of serving children with ADD has resulted in a number of positive outcomes. Assistance and ongoing support are available at the building level to children, parents, and teachers. In most cases, students with ADD receive appropriate modifications in their program and remain in regular classes.

The Broward County public school system has received national attention for developing a model to serve children who are eligible under Section 504. This practice has been presented at national and state professional and parent conferences. The practice has also been described in the report of the Council for Exceptional Children's Task Force on Children With ADD (1992) as well as the National Association of School Psychologists' spring 1993 edition of *Communique*, published by the School systems around the country have asked for information about this practice.

REPLICATION

To replicate this practice, a school system must review Broward County's model of serving children eligible for Section 504 services. Modifications should be made to suit the needs of the particular district. For example, Broward County is an urban district with large schools. The application of assistance teams in small or rural schools may be considerably different.

This system committed to funding for a full-time central office employee to develop guidelines to serve students eligible for Section 504 services, such as children with ADD. The upper-level administration set the stage for support of students with ADD by creating this role, hiring personnel who embrace and expand the district's commitment to this group of children and their families, and encouraging ongoing ADD-related staff development.

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Cooperative Consultation as an Instructional Model
Orlando, Florida

BACKGROUND

Orange County Public Schools, which serves over 110,000 children, created a learning environment in the regular classroom that was positive for students with ADD. It used the concept of collaborative consultation, a program endorsed by the Florida Department of Education. The practice was initiated within specific content areas, with a regular and special educator working as a team.

DESCRIPTION

Orange County Public Schools views cooperative consultation as a method to provide students who have special needs with an opportunity to develop their thinking and social skills in regular education, with support from a team made up of regular and special educators as well as other school personnel. This service model helps instructional personnel build better programs for all children.

Cooperative consultation occurs through a six-step process. It affords educators with an opportunity to examine instructional methods and plan effective strategies to use with all youngsters, especially those experiencing difficulty. This process is outlined in detail in a manual titled *Cooperative Consultation*, published in 1990 by the Bureau of Education for Exceptional Students, Division of Public Schools, Florida Department of Education. All forms referred to in this description are available in this document. The process is described below.

Step 1. Describing the student's strengths and weaknesses. In this practice, the science and social studies teachers review the records of students with ADD and described their needs in terms relevant to education. Then a student inventory is used to outline each child's strengths and weaknesses. This step takes about 15 minutes per child.

Step 2. Describe the general education expectations. The special education teacher interviews the regular education teacher about the expectations for all students in the class. A one-page course description is completed during this interview. This process takes about 20 or 30 minutes.

Step 3. Compare the student's skills with the course expectations. The regular and special education teacher systematically compare the student's skills with the teacher's expectations. When a student with ADD has a weakness where the teacher has specific expectations, a mismatch is noted on the cooperative planning work form. Before going further, the two teachers discuss whether there are other students in the classroom with similar problems. This approach takes the focus off an individual child and addresses the need to educate all children appropriately.

Step 4. Plan for instruction and monitoring. Having identified potential problems, the teachers now work on alternative solutions. They brainstorm strategies to maintain students with ADD in the regular class and then select the most promising intervention. Examples of such strategies include cooperative learning groups, interactive learning, and a range of visual organizers such as vocabulary mapping, Venn diagrams, and webbing. The specifics regarding the intervention are documented on the cooperative planning work form. In rare instances, teachers may conclude the student's needs are so severe they cannot be met in the regular classroom.[1] The time requirement for this step is variable.

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Step 5. Implement instruction. The special education teacher and the regular education teacher jointly instruct the children in the manner outlined on the work form. The time requirement for this step is again variable.

Step 6. Monitor. Monitoring is necessary to determine whether the plan is working. The two teachers plan sessions to evaluate their effectiveness with students with ADD, identifying and discussing specific concerns. If necessary, new strategies are identified and implemented. This step should not demand excessive time — perhaps one hour a month — but varies depending upon the needs of the child.

For this practice to succeed in Orange County Public Schools, the teachers had to commit to the model and learn methods of cooperative consultation. Administrators were key in that they encouraged the teams and provided inservice and training prior to implementing this plan.

Parent involvement was also critical to the success of this practice for students with ADD. The teachers tapped parents' expertise in teaching particular units for all the students. For example, teachers would identify specific skills of a parent (such as woodworking, cooking, or chess) and then build an instructional unit around this activity, with the parent as a guest lecturer. Parents also helped with children in cooperative learning groups. Students with ADD were not singled out, but they were provided additional instructional support and behavioral monitoring as needed.

OUTCOMES

Providing services to students with ADD in the regular classroom reduces the stigma of special education and may even enhance the social status of these children. Certainly, it allows the students to observe appropriate peer models. Students with ADD actively participated in their learning, leading to an overall improvement in behavior and a decrease in the number of discipline referrals. Students with ADD reported they knew and liked others in their work groups and felt they were better known and liked by their peers than when they were in separate special education classes. Teachers reported satisfaction with this model because it provides opportunities to share knowledge, expand skills, generate strategies, and develop creative solutions to classroom problems. The model also provides increased teacher-student contact, which facilitates learning.

REPLICATION

To replicate this practice, a school district must commit to this model of cooperative consultation and provide the necessary training. Teachers must be identified who are willing to share their talents, modify their teaching methods, and consider alternative methods of student evaluation. The Florida model of cooperative consultation is described in forms appropriate for elementary, middle, and secondary school children.

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Increasing Attending Behaviors in Preschool Children with ADD
Des Moines, Iowa

BACKGROUND

The Increasing Attending Behaviors intervention was developed by a school psychologist with a specialized practice in the early childhood special education (ECSE) program of Des Moines Public Schools, an urban school system of 32,000 students. The intervention was implemented for eight years in the preschool component of an ECSE program that serves infants, toddlers and preschoolers. The preschool program is a center-based classroom model that serves 220 children aged three to six, with a minority enrollment of 25 percent. There are 30 classes located in six school buildings, each in a different region of the school district. The classes, which are self-contained or self-contained with integration, meet for two-and-one-half hours daily during the school year.

Services are provided to children with developmental delays or disabilities (e.g., autism, mental retardation, physical disability, communication disability, visual or hearing impairment, and behavior disorder). Many children in the ECSE program have been classified, usually by medical practitioners, as having ADD as a secondary component of other diagnoses.

The intervention was developed through collaborative consultation involving teachers and a school psychologist. In some instances other support staff such as speech language pathologists were also involved. The intent of this joint effort was to help children with ADD develop appropriate behaviors that would foster learning and independence. Parent input was also sought through conferences before the practice was implemented. This practice has been gradually modified to meet the level and needs of a particular child or group of children.

DESCRIPTION

This practice was developed for children with ADD served in the ECSE classrooms, where there are approximately eight to 10 children in each class with a teacher and a teacher's aide. The target behaviors usually involved the need to increase attention and compliance. Initially, the practice was implemented during structured classroom activities, when attention difficulties often were evident. Prior to the intervention, the consultation team determined what constituted attending. This task was more problematic at the preschool level, where academic work was not part of the curriculum. Target behaviors (depending on the child's age and cognitive level) typically included sitting in a chair or on a carpet square, keeping hands to oneself, looking at the teacher or materials, and listening quietly when another student or the teacher is talking.

A photograph was taken of the target child engaged in the identified appropriate behaviors. If more than one child was involved, then each of the children served as a model for a different behavior. The picture session provided an opportunity for the child or children to practice the appropriate behaviors. The pictures were posted as the rules (attending and compliance behaviors expected) for the activity center. The rules and procedures were reviewed daily, and the child or group practiced the behaviors before the activity was started. Occasionally, the teacher chose to use this practice for the entire group, although the goals were focused on the behaviors of the target child or children.

Once the activity began, the teacher set a kitchen timer to ring at variable intervals. An a priori schedule of intervals was established. The intervals averaged out to an amount of time nearly equal to the child's or children's mean length of attention to task as indicated by baseline data. The variable intervals were written on a sheet of paper kept at the activity center. Some teachers preferred to prerecord (on several tapes) variable interval schedules that were played during the activity. In either case, when the timer rang, the teacher directed her attention to whether the child was following the specific rules. When the child displayed the appropriate behaviors, he or she received praise as well as other predetermined rewards, which could include a happy face, an image made by an ink stamp, or food. When the child or children were successful for at least a minimum percentage of time through the total activity, another reward was often given. These rewards could include a "happy note" to parents, a little toy or treat from the reward box, or other special recognition. As the child or children succeeded (by meeting criterion for the percent of time the child was exhibiting appropriate behavior when the timer rang), the teacher increased the average interval size and gradually faded the ringing of the timer.

When the child was not exhibiting the specific behavior at the ringing of the timer, the teacher made no comment and continued with the instruction or praised a peer who was displaying appropriate behavior. The sound of the bell itself was usually effective for tuning the child into what behavior he or she was engaging in, and the child self-corrected. The teacher also ignored any inappropriate behaviors that occurred during the interval, praised another child, or, without looking at the target child, commented that the bell might ring soon. Sometimes an extremely active child has left the group to play in another area. The teacher's ignoring of this behavior was ineffective because the play itself was reinforcing to the child. So, when a child left the group, he or she was immediately placed in a time-out situation. The child stayed there until the timer rang and he or she was ready to participate in the group.

The teacher kept a daily record to indicate whether the child displayed appropriate (rule-conforming) behaviors during the intervals. In cases where the ink stamp or sticker (which were placed on a sheet or paper) served as reinforcers, some teachers used those papers as their data sheets by comparing the number of these rewards the child received with the total number of intervals to obtain the percentage of attending behavior. Teachers have preferred that the consultation team develop forms on a case-by-case basis rather than using standard forms. At times a teacher chose to involve the teacher aide with one or more components of the practice, such as helping to keep data or giving rewards to the child. Teachers sent notes or made phone calls to parents according to agreements between the parents and consultation team.

Ecological manipulation facilitated the goal of increasing attending behaviors. During the structured activities, the child's physical boundaries were defined. The child was seated in a chair or on a carpet square rather than just on the floor, as has often been done in preschool settings. The seat was placed close to the teacher, between two children who usually displayed the appropriate "rule" behaviors. Unnecessary materials, objects, or other distractors were removed from the area when possible. The materials needed for the activity were placed out of the child's line of vision or reach until he or she was to use them. The length of the structured activity was kept reasonable for preschool children, approximately 15 to 30 minutes (with consideration of the child's functioning level). High-interest activities were used to teach concepts. To ease transition to the structured activity as well as termination of the activity, the adult provided a verbal prompt such as "two minutes to go and then..." Even though the child most likely did not conceptualize length of time, he or she became oriented to the idea that change was about to occur.

Because these children were involved in a special education program, all had an individualized education program (IEP). Often at least one goal or objective involved improvements in attending behaviors. Children's progress and the intervention were monitored in part through the IEP process. In addition, a support member of the consultation team, such as the school psychologist, monitored the progress of the child or children, either as part of a monthly child study team meeting or through more frequent classroom visits.

OUTCOMES

In general, the practice yielded positive results for preschool children with ADD. Attending behaviors, typically well below 50 percent at baseline, nearly always increased significantly. Implementation of the intervention also decreased some of the inappropriate off-task behaviors such as running from the group, putting hands on peers frequently (sometimes aggressively), and lying on the floor during the structured activity. According to teachers' anecdotal reports, improvement typically is seen in other activities.

The gains usually lasted for the remainder of the school year, and, in some instances, the timer was phased out completely. If the child or children appeared to be losing some of the gains, the schedule of reinforcement became more intensive.

Parents appreciated the feedback they were given on their children's progress. Some parents rewarded their children with special activities or treats for a positive report.

Teacher feedback to the psychologist about the practice was favorable. Teachers found that the intervention, in addition to being effective, was also easy to implement. Teachers also liked the emphasis on positive, appropriate behaviors. They felt the approach helped to remove pressure from them to constantly remind the child to listen or look: the bell became the cue for the child. The bell also served as a reminder to the teacher to respond to the child's appropriate behaviors. In addition, structure helped teachers know how to deal with inappropriate behaviors. Many teachers have spontaneously used this intervention with other ADD students who exhibited problems with attending behaviors.

REPLICATION

This intervention has been successfully implemented for eight years with different teachers and preschool children. The intervention also could be used with elementary-aged students, particularly those in smaller classroom settings. Most of the components of the practice would be similar to those described with the following exceptions: written rules in addition to pictures could be posted; the definition of attending behavior might differ in the sense of being more specifically related to academic tasks; and the reward system could involve tokens or points that would be exchanged for backup reinforcers such as special activities and privileges.

This intervention has been tried recently with a third-grade student with ADD who was placed in a classroom for children with behavior disorders. His baseline for attention to task during independent seat work was 23 percent. One week after implementation, he was able to attend up to 50 percent of the time and up to 60 percent during the second week. Further replication with this age group is recommended.

The cost for implementation was reasonable: no outside staff was needed, and many of the materials were already available in the school. In some instances other school staff contributed to the reward box or provided materials. To summarize, the materials needed include data collection sheets and reinforcement schedules; stickers, trinkets, food, and, happy notes as rewards; ink stamps or colored markers to make rewards; kitchen timer or tape recorder; and camera and film.

The practice requires minimal training. The psychologist often spends some time during the first few days in the classroom helping the teacher and teacher aide develop the materials and forms. In addition, the psychologist models or cues teacher behavior during the initial trials of the intervention — for example, showing how to praise the child for following the rules or reinforcing peers who display the appropriate behaviors, especially when the target child is displaying inappropriate behaviors.

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Identification Procedures for Children With ADD
Louisville, Kentucky

BACKGROUND

Jefferson County Public Schools, with a student population of more than 90,000, began the process of establishing a school-based educational identification protocol for children suspected of having ADD. The school system wanted a proactive and appropriate method of identifying children using school-based data without relying on private practice evaluations. The system developed two alternative systems into which a child with attentional deficits could be channeled for assessment. One was the existing special education route, available to any student suspected of having a disability. The other option, which is the focus of this report, was a process of assessment that does not involve special education procedures.

DESCRIPTION

The following is a description of the alternative identification process in use by Jefferson County Public Schools to determine if a child's attentional deficits are significantly interfering with his or her educational performance.

1. Any involved person, such as school personnel, parents, or physicians, makes a request for an ADD assessment through the school counselor. The school counselor acts as the case manager and is the designated contact in this system; however, there could be any other building-based contact.

2. The school counselor meets with the family, discusses the concerns, obtains the parents' permission, and then forwards the ADD assessment request to a designated clerical person at the central office.

3. The clerical person logs the request and mails the counselor a packet of materials for school personnel and parents to complete. This packet includes a letter of instruction to the counselor, a checkoff sheet to note when each step is complete, and all the material needed to complete the steps.

Parent: Parent Permission Form (to sign)
Developmental History
Achenbach Child Behavior Profile

Teacher: General Information Sheet
Barkley ADHD Rating Scale
Achenbach Child Behavior Profile

Counselor: Behavior Observation
School Record Review

4. Upon receipt of the packet at the school, the counselor collects the information from the parents and school staff.

5. The counselor returns the information to the school psychologist. The psychologist scores the rating scales, conducts a conference with the parents and teacher, and completes a school observation. This observation typically involves a third party peer comparison of time on task. If necessary, additional assessment is completed with the child. This assessment may include cognitive, academic achievement, and social or emotional testing. The psychologist then produces a written report.

6. The school psychologist informs the counselor when this process is complete. The counselor arranges for a followup conference with the parents, teachers, school psychologist, and other appropriate persons. The school district maintains a 45-day timeline from the date of parent permission to the debriefing meeting with the parents.

7. Results of the assessment are shared at the meeting and recommendations are discussed. At this time the parents and team of evaluators develop strategies to enhance the child's school performance and discuss whether consultation with a medical professional is needed. Dates for followup are individually determined and recorded. A written record of the meeting is maintained at the central office and in the child's folder at school.

The system is currently examining ways to streamline this process and make the referral process more timely. For example, school-based staff could phone in the information to the central office clerical staff and maintain the assessment packets at the school.

The psychological services staff provided districtwide inservice on the new assessment procedures ADD in general for counselors, principals, and teachers. This program was also offered to parents in the district. Administrators from the top down endorsed this system of identifying students suspected of having ADD.

OUTCOMES

After procedures for identifying children suspected of having ADD were developed and implemented, reliance on referrals to outside agencies and physicians for diagnosis dropped immediately. Schools began making appropriate referrals based on their increased awareness of ADD. The school psychology staff won the "best practices" award in Kentucky in 1990 for their innovation in identifying students with ADD. Jefferson County Public Schools also was noted as having a model program in serving students with ADD in *The ADHD Report* (Barkley, April 1993).

As a result of better identification of students with ADD, schools began to focus on providing more effective interventions. Several schools developed school-based inservice programs to equip the staff in making classroom modifications for children with ADD. Two brochures were developed and disseminated to school personnel, parents, and the community. One was an overview of ADD, and the other focused on how to intervene with the children. A districtwide task force was formed that promotes community involvement with educators, parents, psychologists, physicians, and mental health professionals.

A 10 week, half-day Saturday program was developed for children with problems with attention and impulsivity. A parent component was added, capitalizing on parents' strengths in serving children as well as providing parent support and training.

REPLICATION

To replicate this practice, a school district should evaluate the procedures used in Jefferson County and modify them to meet its system's needs. This practice has been used primarily at the elementary level in Jefferson County but has been piloted successfully at the middle and secondary levels with adjustments in assessment procedures. For example, adolescents are asked to complete the youth version of the Achenbach Behavior Checklist. Students this age also participate more fully in student interviews.

The human resources required to replicate this practice include parents, teachers, school psychologists, and school-based case managers such as counselors, clerical staff, and an administrative coordinator. Training is a necessary component of this practice, because schools must have their awareness raised about the specifics of ADD and assessment procedures.

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Classroom Monitoring and School-Home Behavior Management Strategy Omaha, Nebraska

BACKGROUND

The Classroom Monitoring and School-Home Behavior Management Strategy (Classroom/School-Home) was developed through the collaborative efforts of a psychologist and resource teacher. The psychologist provides services to the district on a contract basis, supplementing the district's psychological services. The intervention has been implemented at Swanson Elementary School, one of 10 elementary schools in Westside Community Schools. Westside enrolls 4,800 students; the enrollment at Swanson Elementary School is 260 students. The district serves a primarily middle- and upper-middle-class section of suburban Omaha, Nebraska.

The Classroom/School-Home strategy was implemented with rigorously diagnosed ADD students in regular and special education. Swanson Elementary uses a full-inclusion approach: that is, nearly all students with disabilities receive special education and related services in regular classrooms with limited or no pullout services. Through the cooperative efforts between this district and local physicians, especially the Psychology Department of the Meyer Rehabilitation Institute, behavior interventions typically precede consideration of cerebral stimulant medication. Few of the students in this program were on cerebral stimulant medication. Westside strongly emphasizes the use of regular education resources and programs in providing appropriate programs for students with ADD.

DESCRIPTION

The Classroom/School-Home strategy was applied to classroom survival skills behaviors. Prior research and anecdotal evidence from many teachers confirms the importance of such behaviors in the successful classroom performance of students with ADD. The typical behaviors addressed with this intervention were completing tasks, following instructions, remaining in one's seat, and completing classroom assignments. Target behaviors are selected on the basis of an interview with the teacher and structured classroom behavior observations. The interview and behavioral observations ensure that target behaviors are individualized to the unique behavioral patterns of individual children with ADD.

After target behaviors have been identified, the Classroom/School-Home strategy is established in a conference including the psychologist, resource teacher, classroom teacher, and parent. These discussions lead to clearly delineated classroom procedures and a communication system between school and home.

The Classroom/School-Home strategy requires the following elements: (a) targeting specific behaviors for creation of an individualized school note; (b) meeting with the child's teacher or principal at school to discuss procedures; (c) implementing hourly monitoring and evaluation of the student's behavior; (d) providing hourly feedback (positive and negative) by the classroom teacher; (e) reviewing "tallying" points from the school note (to be conducted by parents and, optionally, at school as well); (f) earning or losing privileges at home based on school behavior; and (g) providing of an "earn back" system to maintain motivation if a poor schoolday has occurred. Sample forms used by this district are included in Appendix E, Intervention Aids.

Reinforcers are devised in a menu format. The child draws reward cards with reinforcers printed on them from the available reward menu. He or she is unaware which reinforcers will be supplied that day. This procedure keeps the child from selecting the reinforcers that are most valued and also provides an element of chance. It is recommended that one-third of the cards be changed each month to ensure that a new set of reinforcers is employed, thus maintaining the novelty. Once target behaviors improve to levels specified in the goals, maintenance and generalization of behavior change is promoted by using changing criteria for meeting goals, thinning reinforcement delivery, and fading prompts and contingencies.

The time required to implement this procedure is modest in view of the concerns expressed by classroom teachers about disruptive behaviors by students with ADD. The initial interview with the classroom teacher to establish probable target behaviors typically requires 15 to 25 minutes. A next highly desirable step, though optional in many applications, is to gather baseline data on each of the potential target behaviors through systematic classroom observation. On the basis of the initial teacher interview as well as observational data, target behaviors are established in a meeting with the teacher, parent, and, if appropriate, the student. During this conference the Classroom/School-Home strategy is explained, communication procedures are established, and agreement among the parties is negotiated regarding responsibilities. Other information may be provided at this meeting, such as articles on ADD and classroom behavior interventions. Participants are cautioned to not expect immediate or dramatic changes in behavior; typically, significant effects are apparent within two weeks.

OUTCOMES

The outcomes of the Classroom/School-Home strategy typically are evaluated on the basis of teacher and parent judgment of the changes in behavior. Results are analyzed, and computer graphics of student performance outcomes are generated. The graphs have been particularly helpful in maintaining the motivation of teachers, parents, and students.

Children with ADD nearly always improved significantly with this intervention. Teachers recognized the substantial improvement in the quantity and quality of classroom work, increased student capability in conforming with classroom procedures, and improved classroom climate for all students. The parents were equally positive about changes in academic performance and the opportunity to establish positive interactions with the child regarding school performance.

REPLICATION

This procedure is relatively easy to implement and inexpensive to employ. Some prerequisites to successful implementation are: (a) technical expertise in behavioral interventions; (b) an onsite case manager to monitor and troubleshoot implementation; (c) parents willing to cooperate with the procedure; and (d) school officials willing to identify target behaviors, monitor daily performance, and provide information to parents. The procedure has been used with considerable success with children ranging in age from 5 to 14 — less so with children above age 14, although the home-school note procedure has been used successfully with high school students.

One of the strengths of this intervention is the involvement of parents in all phases from selection of target behaviors to evaluation of results. The high rate of success produces more positive relationships between parents and school officials. This program also has been developed with input from community and parent advocacy groups such as Children with Attention Deficit Disorder. The program is based on a continuing relationship between the Meyer Rehabilitation Institute at the University of Nebraska Medical Center (Meyer runs a weekly ADD clinic) and Westside Community Schools.

Training of approximately one hour was carried out with all school employees in the Swanson Elementary School before the strategy was used. The training occurred as part of an inservice program at the school and included information about ADD, behavioral interventions, and home-school behavior management strategies.

Additional training was given for individual teachers as students with problematic behaviors related to ADD were identified. The additional training, typically less than one hour, focused on identifying specific target behaviors, observing behaviors, tallying results, and writing school-home notes.

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Screening Procedure for ADD
Raleigh, North Carolina

BACKGROUND

To establish a consistent and appropriate procedure for serving students suspected of having ADD, the psychological services staff at Wake County Public Schools, population 70,000, developed an ADD screening procedures manual in 1991. The manual provides a specific method for conducting a systematic screening procedure with students experiencing difficulty with attending to and completing assignments. This procedure is now used district-wide by teacher assistance teams when an Attention Deficit Disorder is suspected. Wake County has a long history of using teacher assistance teams with children who have academic or behavior problems, and the procedures developed to screen students with ADD rely heavily on this proven model.

DESCRIPTION

Once developed, the ADD screening procedures manual was sent, along with a cover letter explaining the process, to all Wake County schools. The manual includes the following information: a recommended procedure for ADD screening; general information on ADD; classroom interventions and strategies; recommended home and school behavior rating scales; and information on obtaining additional scales and interpretive manuals. The manual also includes interpretation forms to assist in reporting rating scale results and a summary checklist of information that should be sent to a pediatrician when a child is referred for medical evaluation.

As part of the systematic screening procedure, teacher assistance teams implement the process of screening students with suspected attentional problems. Assistance teams composed of a variety of personnel (e.g., principals, assistant principals, regular and special educators, counselors, school psychologists, and speech/language therapists) were already functioning in all schools. The ADD process makes use of existing procedures used by these teams in addressing students' learning and behavior problems. Where assistance teams were overburdened, separate ADD screening committees were formed. The psychologist assigned to the building-based team provides inservice training on ADD, as well as the specifics of the screening procedure. The typical training provided to school-level personnel consists of: an overview of ADD; a rationale for developing the screening procedure; an overview of the screening process; and methods for accessing local resources on ADD. School psychologists also participate as members of building-based teams.

When a referred student exhibits characteristics of ADD, the following process is initiated:

1. The classroom teacher develops and implements an intervention plan to help the child succeed in the regular classroom. The ADD screening procedures manual provides a wide range of suggestions that help to stimulate ideas for managing children in the classroom. Teachers are encouraged to try an intervention plan daily for at least two weeks. At the end of that tine, the effectiveness of the plan is evaluated.

2. If the two-week trial intervention is not successful, the teacher presents the case to the building-based assistance team or ADD screening committee.

3. If the team agrees that the student should continue to be screened for possible ADD, a screening form is completed. In addition to identifying data, this form includes a record of parent contacts; classroom observation information; a review of school and medical history, social functioning, and interventions attempted; and documentation of the appropriate next steps. Parents are notified, and permission to complete the ADD screening process is obtained.

4. The child's vision, hearing, general health, and speech/language processes are screened. Educational testing is completed to determine whether the child has any significant problems.

5. Additional observations of the child are completed by the school psychologist or another member of the assistance team. A time-on-task observation is recommended that consists of observing on-task behavior of the referred child compared with that of a non-referred peer.

6. The following instruments are completed: the Conner's Parent Rating Scale and the Conner's Teacher Rating Scale or the Attention Deficit Disorder Evaluation Scale and the Home and School Situations Questionnaires-Revised.

7. The assistance team reviews the data to determine whether there is a significant pattern of ADD characteristics and discusses the data with the student's parents. If further medical evaluation is needed, the parents may pursue private services or use the physician that is employed by the school to complete ADD evaluations. The school's physician has access to all the information collected by the teacher assistance team. The doctor integrates the information from the school, conducts an examination, makes a diagnosis, and writes a report to the family and the school. If ongoing medical management is required, the school physician attempts to link the family to appropriate medical services in the community.

8. After the medical evaluation has been completed and the child has obtained medical treatment (if indicated), the assistance team determines whether the child requires additional modifications within the regular school program or special education services. Children suspected of having co-occurring disabilities along with the attentional deficits may receive additional evaluations to determine eligibility for services. Children with ADD in the Wake County Public Schools are served under IDEA in the category of "Other Health Impaired", if ADD is their primary disability and their needs warrant specially designed educational services.

OUTCOMES

The ADD screening procedure provides a consistent and appropriate guide for school personnel in dealing with children who demonstrate ADD-like behaviors. It requires the classroom teacher and the assistance team to thoroughly investigate why a child might be exhibiting such behaviors before a recommendation for further medical evaluation is made. This process alerts school personnel to the fact that there may be numerous reasons why a child is inattentive, impulsive, or overactive. School personnel now appear to have a better understanding of why more than just an ADD rating scale is necessary when screening students with attention problems. Elementary teachers are now more concerned with determining what causes the attention problems and the overactivity than with the children's medication.

The ADD screening procedures also assist the school in determining the need for additional medical evaluation. This decision is based on a significant amount of information. In addition, due to increased understanding of ADD by school personnel, student referrals are more appropriate than in the past.

Commitment from school staff to work with families who have children with ADD emerged as a secondary benefit of this practice. One school held a lunch hour ADD workshop where parents and school staff shared a meal, information on ADD, and behavioral management strategies.

The Wake County Public Schools received considerable recognition in North Carolina and nationally for developing a proactive approach to working with children who exhibit ADD-like behaviors, their families, and community service providers. The practice was described in the March 1992 National Association of School Psychologists newsletter. As a result of this article, the system received over 400 requests of additional information regarding the practice.

REPLICATION

To replicate this practice, a school system should review the model ADD screening procedures developed by Wake County and modify them to meet the unique needs of their local schools. It is essential to use assistance teams to develop, implement, and monitor intervention strategies prior to formal referral for ADD. Also critical to the success of this program is administrative understanding and support. Wake County Public Schools tries to meet students' needs in the regular classroom with help from the assistance teams. However, if more structured support is needed, they move to special education for delivery of services.

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Identification and Medical Collaboration Plan
Salisbury, North Carolina

BACKGROUND

The Rowan-Salisbury School System, which serves a primarily rural population of 16,500 students, recognized the need to identify and serve students with ADD. There were two issues the system wanted to address. First, it wanted to develop and implement procedures to meet the needs of students with characteristics of ADD prior to formal assessment for special education. Second, because many children with ADD require medical management as part of their treatment, the system wanted to enhance collaboration among schools, families, and the medical community. To address these needs, the school system employed a full-time ADD support teacher funded by local dollars to create procedures, assist schools in implementing them, and act as a liaison to the medical community.

DESCRIPTION

Under the Rowan-Salisbury process, if a teacher suspects a child has attentional deficits that are interfering with his or her educational progress, the teacher presents the case to the guidance counselor. The guidance counselor serves as the building-based case manager for all such referrals. Then the referring teacher, guidance counselor, and other appropriate building-level professionals identify specific needs of the student and develop strategies to try in the classroom. If these strategies are not successful after a reasonable period of time, the counselor, school nurse, or school psychologist observes the student in the classroom to gather additional data on the behaviors of concern. Also, the ADD support teacher may be called on to assist building-based educators in developing intervention strategies or observing the student. If additional information is needed, parents are asked to participate in a problem-solving process. Initial strategies are reviewed and new intervention strategies are developed, implemented, and evaluated. If the school-based management strategies are not sufficient to meet the needs of the student, the school assists the family in pursuing a medical evaluation.

Rowan-Salisbury realized that physicians need specific school-related information for an accurate diagnosis. Therefore, school personnel developed relationships with 17 local doctors treating children with ADD. The school system provides organized, current, and relevant data to the physicians; in turn, the physicians cooperate with the schools to meet the child's educational needs.

The information sent to the physicians includes a cover letter outlining the child's problems as the school perceives them and a summary of collected data; a checklist of the 14 symptoms associated with ADD in the Diagnostic and Statistical Manual (DSM) III-R and the severity of each symptom; a summary of the child's school history including past behavior and academic performance; scores obtained from both the parent and teacher versions of the Conners' rating scales; a release-of-information form; a medical report form; and a self-addressed, stamped envelope so the physician can report to the school information regarding the type of medical treatment initiated, if any, suggestions the physician has for the school, and the need for followup. If a child is placed on medication, the Rowan-Salisbury School System sends the doctor a followup report after two weeks.

Doctors have been willing to collaborate with the schools and have voiced appreciation for the level of data provided to assist in the medical management of referred students. In addition, local physicians have attended and led inservice sessions on ADD. They also provided a critical review of the proposed school procedures for managing ADD cases.

If a child is diagnosed by a physician as having an attention deficit disorder and is receiving medical treatment, the school and family may develop a regular education plan (REP) for the student. The REP lists the child's needs, strategies for addressing them; a date for REP review and evaluation of the plan; and the parent's, teacher's, and principal's signatures. REP's are routinely evaluated and modified during the first semester of each school year.

Students in this school system who need more intense support than the regular education program offers are eligible for further evaluation and possible special education services. However, the process emphasizes that before special education is resorted to, students who exhibit attentional deficits should have interventions implemented in the regular classroom, have a REP in place for a reasonable length of time with appropriate modifications to regular programming, and have their medication needs addressed.

The ADD support teacher is a key component of this practice. This teacher, assisted by other school personnel, physicians, and parents, developed the procedures implemented in the practice and wrote the *Rowan-Salisbury Schools Attention Deficit Hyperactivity Disorder Handbook* to describe the process. In addition, the ADD support teacher provided inservice training on the ADD referral process for elementary personnel. She is available to assist with individual cases and provide specific information on ADD to guidance counselors. Also critical to the implementation of this practice is the use of guidance counselors as building-based case managers in the ADD referral process.

OUTCOMES

Since the implementation of the referral process, the number of students identified with ADD has doubled. The Rowan-Salisbury procedures facilitate the identification of children with ADD. Approximately 4 percent of the student population in the system is identified as having ADD. As a result of correct identification and intervention, many of the students are experiencing success in the classroom for the first time. Parents are enthusiastic and supportive of the system's efforts, due to the increased positive communication between the school and home. Teachers report a higher degree of comfort in working with students with ADD and appear to put more effort into trying to reach and teach children with attentional problems.

REPLICATION

To replicate this practice, a system would need to evaluate the procedures developed by Rowan-Salisbury and modify them to meet the needs of its individual district. Rowan-Salisbury is a relatively rural system that relies on its collaborative relationship with the medical community, families, and school personnel. The practice as developed is used primarily in elementary schools, with limited implementation in middle and high schools.

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OTHER PROMISING PRACTICES

Project for Attention-Related Disorders (PARD)
San Diego, California

BACKGROUND

The focus of the Project for Attention-Related Disorders (PARD) practice is to provide the support needed to keep children with ADD in the regular classroom. PARD started in 1990 as a result of a 3-day conference on ADD, which was held in San Diego and attended by school personnel (teachers, nurses, psychologists, counselors), parents, and community professionals. Many problems and frustrations were expressed during the conference, because the number of children with attentional problems was increasing and there was no systematic approach to identification or intervention:

- School nurses did not always know where to send children for referral or have appropriate information to disseminate.
- Teachers were frustrated and perplexed over meeting the needs of these sometimes disruptive, always challenging children.
- Parents often did not understand the disorder and were searching for appropriate care, often exhausting their financial and emotional resources.
- Obtaining an accurate diagnosis of ADD was often difficult, since so much of the diagnosis depends on observation and knowledge of the child, and typically little communication occurs between schools and physicians. The need for integrated services had been clearly identified.

PARD was conceived by two physicians advised by a group of individuals from the school and the community. These individuals obtained a 5-year grant from Student Services Division (formerly the Health Services Department) of San Diego Unified School District, also known as San Diego City Schools. PARD is supported in part by the Maternal and Child Health Program (Title V, Social Security Act), U.S. Department of Health and Human Resources.

DESCRIPTION

Through PARD, Student Services created a core team of itinerant school personnel to serve as consultants to all the schools in the district. The ultimate goal is to create teams of well-trained, school-based professionals and community service providers in schools throughout the district.

This core team, consisting of a nurse, two school psychologists, and a counselor, came with training and personal experience in ADD. Although this background was not a requirement for working on PARD, it proved to be helpful in the ensuing work with parents and teachers.

The following objectives were targeted:

1. Increasing the knowledge base of people who work with ADD students: school personnel, parents, community physicians, and other community providers such as sports coaches and scout leaders.
2. Improving coordination between school services and community services.
3. Establishing an ongoing school-based system for identifying, evaluating, and managing ADD students.

Core Team

The roles of the core team members were as follows.

Nurse

- Monitor and coordinate project activities
- Consult with the district's physician consultant
- Interact with the funding source
- Participate in data gathering
- Facilitate monthly meetings with the PARD team
- Function as a resource nurse for medication review
- Participate in inservice training

School Psychologists

- Provide consultation on identification and intervention
- Coordinate data collection
- Complete psychological and educational assessments
- Provide inservice training
- Consult with parents and physicians
- Develop and implement needs assessment for support groups
- Develop an information booklet for parents

District Counselor

- Organize and facilitate onsite parent meetings
- Issue personal invitations to parents regarding parent meetings
- Refer families to appropriate agencies
- Provide information to schools on topics of concern

School nurses were heavily relied on to be the liaison to community-based health care providers and to monitor children's progress. Other specialists in the school, such as district counselors and psychologists, monitored other areas such as social skill development, strategies for classroom interventions, and parent support. The inservice component to schools was a major component of the grant; resources were provided for intensive inservice training to school staffs. The core team was also available to assist school personnel with particular challenges in their schools.

Additional resources that proved very valuable were San Diego's mentor teachers and three consultants.

Mentor Teachers

Many of the San Diego school district's mentor teachers worked on PARD. Teachers in the mentor teacher program must have a special project and document 60 hours of volunteer work beyond their regular duties.

From that group came a knowledgeable teacher who subsequently assembled a teacher intervention manual for preschool-aged children with ADD, *Hard to Reach, Hard to Teach: Meeting the Challenge*. The manual describes how to use multisensory instructional techniques in the classroom, various ways of organizing classrooms, and numerous academic strategies that teachers in San Diego have found useful with challenging students. This manual, authored by Sandra Rief, is now revised and available through National Professional Resources, Inc. at (800) 453-7461.

Consultants

Three individuals in the community with specific experience and expertise in ADD were enlisted as consultants and served as resources to the core team. One of the three wrote (through the PARD grant) a manual titled *School Physician Collaboration for the Student with Attention Difficulties*, which is available from PARD. This manual includes all of the assessment and followup tools, information about the different specialists who may be involved with an ADD child, assessment tools for physicians, classroom strategies, and a bibliography.

OUTCOMES

The PARD core team acknowledges that some schools have been more successful than others in their efforts to support children and families who struggle with attentional problems. Nevertheless, in the three years the PARD project has been functioning in San Diego City Schools, definite positive changes have occurred. Seventy-five children have been affiliated with PARD to date. When school and community professionals work together with families, wonderful success stories result. Children are supported in the regular program with appropriate classroom and medical interventions.

REPLICATION

To replicate this project, funding beyond the local district budget may need to be sought. This project requires school administrative support and a team of school professionals dedicated to the work of ADD. The school system allows one nurse one day per week, one counselor for a half day per week, and two school psychologists one day per month each to work on PARD activities. The PARD grant pays the salary of those individuals for that time allotment as well as for consultants, materials, and supplies used in ADD grant activities.

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Comprehensive ADD Seminar
Colorado Springs, Colorado

BACKGROUND

Teachers and parents in Harrison School District No. 2 had expressed their desire for more knowledge about ADD so that children who had this disorder could be identified and appropriate interventions could be developed. In response, a school social worker and a school psychologist in Colorado Springs, Colorado, developed this seminar.

DESCRIPTION

The school social worker and the school psychologist worked as a team to develop the seminar, which consisted of five 3-hour sessions. The topics treated were an overview of ADD, medical intervention, legal issues, interventions, and community resources.

A comprehensive learning approach was offered. All parents, teachers, and support staff from the school district who were interested in understanding ADD and learning techniques for dealing with students with ADD were invited to attend. Special education teachers throughout the school district compiled a list of names of parents whose children were known to have ADD, and fliers were sent to them as well as to all educators in the district.

Guest speakers were brought in to present the content of medical and legal issues. Points were made with games and activities. For example, to illustrate the perspective of students with ADD, the presenter read a boring paragraph aloud to the "class" while three different radio stations played loudly; then the presenter led a discussion of the paragraph that had been read.

The developers of this practice arranged with the local college to make this seminar equivalent to 1 graduate hour of work toward teacher recertification.

OUTCOMES

Feedback and formal evaluation on the seminar have been positive. In several instances, parents agreed to medication therapy for their ADD children after years of resistance, teachers experienced success with ADD children in their classrooms, and both parents and educators felt optimistic about the availability of effective interventions.

There have been numerous requests for future classes, and the next scheduled session will be filled to capacity.

Another encouraging outcome is that an ADD parent support group is being established at the grassroots level as an outgrowth of the initial class.

REPLICATION

The development of this seminar relied heavily on current ADD research literature and on community and parent input. But most important, it relied on the creativity of the originators for the format. The developers had background in ADD and therefore needed little training to conduct the seminar. To replicate this practice, presenters should have expertise in the content and be experienced trainers. The format of the seminar would need to be tailored to meet the specific needs of the school, parents, and community. A spirit of collaboration and teamwork was essential in developing, implementing, and evaluating this practice.

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Collaborative Evaluation Technique
Norwich, Connecticut

BACKGROUND

Norwich Public Schools developed an identification technique to aid in accurate and early identification of students with ADD. The evaluation practice has been gradually refined until, through inservice training, it is now used consistently by all the staff psychologists in the school system. In addition, workshops have been offered to teachers to give them more information on ADD, describe the ADD evaluation technique, and suggest classroom strategies.

The evaluation technique, which is based on the work of Russell Barkley and George DuPaul at the University of Massachusetts Medical Center, Worcester, has been found efficient and effective in this school system.

DESCRIPTION

The Child Study Team and the Planning and Placement Team are integral parts of the ADD evaluation process.

Child Study Team

The Child Study Team (CST), consisting of a variety of school professionals, is a support service available to all regular education teachers in Norwich Public Schools. Teachers who need help in addressing individual students' needs can refer the student to the CST.

When the CST meets, the school psychologist explores problems of inattention, impulsivity, and overactivity for the possibility of ADD. The school psychologist also reviews the interventions that have been tried and either recommends modifying those interventions or refers the case to the Planning and Placement Team (PPT) for further evaluation.

Planning and Placement Team

The PPT usually consists of the school psychologist, the school principal, the classroom teacher, a special education teacher, and the parents. Parents are considered important members of the PPT; they are always invited to attend meetings and encouraged to participate. When the PPT determines that ADD or other special education needs are present, a referral is made to the school psychologist for an ADD evaluation to be done.

Evaluations

Written consent from parents is obtained before an evaluation is done. The evaluation might target ADD alone (the subject of this practice), or it might also address such other matters as current educational levels, the possibility of a learning disability, emotional disturbances, or cognitive delays.

After the referral for evaluation and the parents' consent have been processed, the psychologist pulls an ADD evaluation packet from the file in the school office. This packet contains a form cover letter from the psychologist to the teacher explaining the evaluation process and a number of scales, or questionnaires, for assessing ADD.

The teacher is asked to send the following scales to the parents with a request that they be completed and returned.

- Child Behavior Checklist
- Home Situation Questionnaire (Revised)
- ADD Rating Scale for Parents

In the cover letter, the teacher is asked to complete the following scales:

- Teacher's Report Form
- Conner's Teaching Rating Scale
- School Situations Questionnaire

- Academic Efficiency Scale
- Academic Performance Rating Scale
- School Situation Questionnaire (Revised)
- ADD Rating Scale for Teacher

After receiving the completed scales from the parents and the teacher, the school psychologist completes the following:

- Child Behavior Checklist (Direct Observation Form)
- Academic Situation Coding Sheet
- Behavioral Observation Sheet

The school psychologist writes an evaluation report covering the following topics:

- Analysis of all the data provided
- General information about ADD for teachers and parents
- Specific information for classroom teachers to help children improve attention span and concentration abilities
- Strategies for parents to do the same

The evaluation report is reviewed with the parents at a followup meeting of the PPT. Sometimes the PPT determines that a child needs special education and related services, but usually the PPT determines that the child should remain in regular education settlings with classroom modifications and supportive services.

In the same meeting the psychologist discusses the research that has demonstrated the effectiveness of medical interventions for children with ADD. The decision whether to pursue medical treatment is left entirely to the parents, and they are strongly encouraged to share the evaluation report with the child's physician to help with the medication evaluation. When children are placed on medication, the school monitors behavioral and academic differences and side effects and provides feedback to the physician and family.

OUTCOMES

The teachers have become more aware of the effects of ADD on school functioning. They are more alert to the early signs and symptoms of ADD and are bringing these concerns to the attention of the Child Study Team sooner. As a result, the school psychologists have been able to readily followup on these concerns and identify ADD children early.

Most teachers and parents appreciate being an integral part of the evaluation process. Teachers and parents seem to be particularly interested in comparing home and school observations; the evaluation practice fosters close coordination. The importance of working together is further emphasized at the followup PPT meeting. Parents appreciate the formal report they receive, and they perceive that they truly are an important part of both the evaluation and the treatment plan. Consequently, parents are generally quick to contact their family doctor to share the information they have received.

This practice has led to the early identification of ADD needs in an efficient and effective manner. Multifaceted treatment plans can be put into effect before children have experienced inordinate frustration and failure.

REPLICATION

This practice can be replicated in any elementary school where some school psychological services are available. School psychologists are generally familiar with the use of behavioral rating scales and evaluations; those who are not would need specific inservice training in this area.

Any materials that are necessary are readily available from commercial publishers or could be obtained from the Norwich Public Schools chief psychologist. The cost of implementing this practice is minimal, and professional time is used efficiently.

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Daily Checksheet
Suffield, Connecticut

BACKGROUND

The practice of using a daily checksheet was developed by a special education teacher working in a middle school setting, where many of the students in the special education program have a diagnosis of ADD. The goals of the special education program are to equip the students with skills for succeeding in regular education classes and to monitor their progress carefully while they are in the special education program.

The daily checksheet strategy is a method of continuous, consistent communication between the special education teachers and the regular education teachers who work with the ADD students, as well as an ongoing communication system between home and school.

DESCRIPTION

The Checksheet Form

A checksheet form is individually designed for each student, listing individual criteria that are directly related to each student's goals and objectives. In the far left-hand column are listed all class periods, academics, physical education, study periods, and so on. The next columns are for each student's criteria, and the grades. Abbreviated to fit the space available, the following might be some of the criteria on a student's checksheet:

- Is on *time* for class
- Is *prepared* for class with appropriate materials
- Displays appropriate on-task *behavior* for independent work
- *Attends* to or participates in classroom instruction and discussions

- Completes assigned *homework*
- Produces *quality* work

The grades are multiple-choice decisions for the teachers. For example, for the "Behavior" criterion, each teacher circles "good," "fair," or "poor"; for "Prepared on Time," each teacher circles "yes" or "no"; and so on.

A block is provided for the student to write what the homework assignment is and for the teacher to write comments. The last column is for the teacher's initials.

Using the Checksheet

The steps in using the checksheet are as follows:

1. At the beginning of the schoolday, the student drops off the previous day's checksheet and picks up a new one.
2. The student goes to the first class. The student writes the homework assignment in the appropriate space on the checksheet. For example, on the Math row of the checksheet the student might write, "First 10 problems on page 25." If no assignment is given, the student writes "none."
3. The student brings the checksheet to the teacher at the end of the period. The teacher verifies that the assignment has been noted correctly, circles the appropriate grade for each criterion, writes any additional comments, and returns the checksheet to the student. This step is repeated for each period.
4. The student returns to the special education classroom at the end of the day, where special education staff record the grades on a tally sheet.
5. The student refers to the checksheet in deciding which books to take home for doing homework assignments.
6. The student takes the checksheet home for parent signature.
7. The parent is encouraged to use the checksheet in monitoring the student's completing of homework assignments.

OUTCOMES

The most notable success of the daily checksheet practice has been with the students. With use of this strategy, most special education students who are mainstreamed (put in regular education classes) for academics remain successfully mainstreamed.

Students' reactions to the checksheets are nearly as varied as the number of students. For the most part, the students accept the need for the checksheet. Many students consider it a tangible tool that helps organize the daily requirements of school, such as what materials are needed and what assignments are to be completed. Students ask to see previous days' checksheets to check on work they did not complete. Even though few students really enjoy having a checksheet, many see the value of it, and some set for themselves the goal of being able to function without that level of assistance.

The special education teachers have found these checksheets invaluable. With more than 20 students in the program, the checksheets have proved to be an efficient way of monitoring each student. They provide easy access to information about requirements for mainstream classes, and at the same time they indicate areas where students need assistance. Information from the checksheets can be used as a basis for discussing areas that need improvement and plans for bringing about beneficial changes.

The checksheets are an immediate form of communication between mainstream teachers and special education teachers. As a result, an awareness of partnership for the benefit of students has been fostered between mainstream teachers and special education teachers.

School psychologists use the checksheets during weekly counseling sessions with the students. Goals can be established on the basis of the student's progress on the checklist criteria. The psychologist can focus discussion appropriately and efficiently by referring to the student's daily checksheets.

Parents have been particularly supportive of the checksheets, because they help parents monitor study time at home and they keep parents informed of their child's progress. Since parents are required to sign the checksheet each day, checksheets have become a good vehicle for communication between home and school. Parents feel comfortable writing notes on the sheets to ask questions, express concerns, describe difficulties the child is having, or just comment. Parents have also used the checksheets to set goals with their children, allowing them to earn special privileges.

The checksheets are also used by some mainstream teachers, guidance counselors, administrators, and parents for students in the regular education program. Several students have even requested them without the knowledge of their parents or teachers.

REPLICATION

The daily checksheet practice can be used in any middle or secondary school. The cost involved is minimal, and no specialized training is needed. Teachers, students, and families must be willing to work together to maintain the daily monitoring of assignments.

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Five-Level Point System
Bradenton, Florida

BACKGROUND

Wakeland Elementary, a school of 629 children from diverse backgrounds, provides preschool through fifth-grade instruction. It has a self-contained special education program for children with behavior and emotional disabilities. With the help of this practice, a five-level system of earning points for appropriate behaviors, children with ADD in special education have been making successful transitions to the regular program.

DESCRIPTION

When children enter this special education program, they begin with an orientation to meet their new teachers and classmates. The five-level system is explained to them, and they are invited to ask questions. The classroom rules and the consequences of not following the rules are also explained. Cool-down procedures are reviewed, and the point system, a mechanism for monitoring and rewarding good behavior, is explained.

The five-level point system works this way: Each child starts at level 1. To move up to each succeeding level, the child must meet certain behavior expectations every day for 1 month, such as following the established rules, participating in group, and behaving in a respectful manner. At level 1, 60 percent of total points must be earned; at level 2, 70 percent; at level 3, 80 percent; at level 4, 90 percent; and at level 5, more than 90 percent.

At each succeeding level, privileges are increased. After being at level 5 for 1 month, the student is eligible to return to the regular classroom on a trial basis; the student has consistently maintained appropriate behavior in a variety of situations over time. Monitoring of the trial mainstreaming begins and the student is supported during this transition time.

At the end of each day, each child has a discussion with the special education teacher about the day's behavior. A daily report card is sent home with the child to the parents, and a graph is used to chart each child's progress.

This practice is characterized by its emphasis on behavior management, with focus on the child's emotional, social, and academic progress. Individualized educational programs are employed, counseling is provided to the children, liaisons with the medical community are established, and parent education programs are implemented.

OUTCOMES

The children in the special education unit have gained positive self-concepts. They express their thoughts and feelings readily, and they have learned how to regulate their own behavior. At the same time, they are also building and maintaining relationships.

School suspensions have been eliminated, and mainstreaming in regular education classes has increased. The unit no longer carries the stigma of being for students with deficient or delinquent behavior. The unit takes part in all school activities and is recognized as a productive and contributing component of the education community.

Parent involvement has risen dramatically since the five-level system was implemented in the special education unit.

REPLICATION

Wakeland Elementary's special education program is funded by the double-basic cost factor. That is, per-child allotments are double to provide money for supplies, equipment, materials, and rewards for appropriate behavior. Each teacher is provided with a telephone and answering machine in order to increase home-school communication.

In addition to funding, this program requires a reasonable teacher-student ratio so that behavior can be monitored accurately. Accurate monitoring may be difficult to do in a regular classroom unless an aide is available. The teacher must be well versed in applied behavioral analysis.

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Target Behavior of the Day
Jacksonville, Florida

BACKGROUND

An education therapist working in a psychiatric hospital developed the Target Behavior of the Day (TBD) practice for use during classtime with all elementary-aged children who are patients at the hospital. Multilevel reinforcements resulting from compliance are used to encourage the children to model the daily target behavior.

The practice specifically focuses on increasing the ability of children with ADD to control their impulses and think of consequences. The goal is to give the children the opportunity to improve their social and academic behavior in the classroom by motivating them to think about good classroom behavior on a daily basis. Parents receive a daily report card about the child's performance on the target behavior.

DESCRIPTION

There are two TBD methods. Which one is used depends on the student's age and the severity of ADD symptoms.

Method One

Method one is for children who are of elementary school age or whose ADD symptoms are severe. In a group setting, the teacher starts a discussion about good social and academic behavior and asks students to help make a list of specific behaviors that are desirable in the school setting, such as

- raising your hand;
- listening when others talk;

- behaving safely on the playground;
- waiting your turn;
- speaking with an "inside" voice;
- saying please, thank you, excuse me, and you're welcome; and cleaning up your area.

The teacher writes each behavior on a large strip of poster board (in Jacksonville the strips are laminated for greater durability). An area of a bulletin board is designated the TBD space. Each morning the teacher chooses a target behavior and posts it on the bulletin board, and students spend a few minutes discussing it and giving examples.

During the day the teacher records a tick mark on the "tally card" each time a student displays the target behavior. The "tally card" is a simple form with spaces for the date and the name of the target behavior at the top and the names of the students listed down the left-hand side. It works best as a 3 by 5 index card that fits in a pocket.

At the end of the day the teacher recognizes — with an announcement and a reinforcement such as a sticker, a star, or the like — the students who displayed the behavior. Some behaviors, such as writing down the homework assignment and cleaning up the area at the end of the day, can occur only once a day; for behaviors that may occur often, the teacher must decide in advance how many occurrences will earn a reinforcement.

Method Two

Method two is for children who are of middle school age or who have mild to moderate ADD symptoms. After the students have discussed desirable social and academic behaviors and the teacher has listed them, the teacher wraps up by explaining that tomorrow he or she is going to choose one of the behaviors on the list and record who displays that behavior.

The difference with method two is that the students do not know which behavior the teacher has chosen. This method challenges students to try to display all the desirable behaviors so as to gain recognition at the end of the day.

The list can be posted on the TBD bulletin board as a visual aid. The tally card is used for recordkeeping, one behavior per card. At the end of the day the teacher announces what the target behavior was and rewards the students who displayed it.

OUTCOMES

The TBD practice has been extremely effective in improving classroom behavior. Before TBD, students were inattentive, rude, impulsive, unmotivated, and often hopeless about school. At first, the older children worked very hard in method one to display the target behaviors, but improvements in behavior did not carry over from day to day. Method two motivates them, though. Some children seem to enjoy trying to win what they perceive as a game. Carryover of all the acceptable behaviors increases dramatically as students try to increase their probability of exhibiting the target behavior and receiving recognition. As social behavior improves, so does academic achievement. With fewer behavioral distractions, students' attention to task increases.

This practice achieves the goal of improving behavior, both social and academic, without separating the children with ADD from their peers. The practice is fun, challenging, and positive, with no punishment involved. On a daily basis it reinforces that individuals are responsible for their behaviors and that they can begin to control them.

REPLICATION

This practice could easily be replicated in a public school setting. Very few materials and very little preparation time are needed, and little is required of teacher and student to carry it out.

Some families have tried the TBD practice at home to increase positive behavior. Parents are encouraged to choose specific behaviors with the help of their children.

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Student Involvement Plan
Lake Villa, Illinois

BACKGROUND

A teacher working in Lake Villa Intermediate School with seventh- and eighth-grade students with ADD developed this practice to help students in regular education classes form positive classroom behavior, study habits, and organizational skills and to improve their feelings of self-worth. Student involvement is emphasized.

DESCRIPTION

The teacher began by calling a conference at the beginning of the school year with the parents of students with ADD, the principal, the special education coordinator, the social worker, the resource room teachers, and all of the ADD students' regular teachers. The specific strengths and weaknesses of each student were discussed, needs were described, and a general plan was agreed on and outlined in writing.

Then the teacher had a problem-solving meeting with each student, the student's parents, and other relevant school personnel. Details of how the school and family together could help each student accomplish the target behaviors were discussed, and the plan outline and its goals were described.

In one case, the student uses an assignment notebook to write down homework assignments every day. Parents and the student established a positive reinforcement system in which the student earns points toward baseball cards by completing the assignment notebook each day. A designated adult, such as the teacher, counselor, or school psychologist, checks the notebook at the end of each schoolday or each morning or both. A transition fade-out procedure is implemented, so that the student and parent can monitor assignments without the teacher having to be involved daily.

The teachers take 5 or 10 minutes each Friday to write a brief progress report, describing the students' behavior, effort, classroom performance, homework completion, and present grade average. The students collect the reports at the end of each class on Friday and bring them to a designated adult at the end of the day. In about a 15-minute meeting, each student-adult pair read and discuss the reports, evaluating how everything is going and whether any adjustments or parent conferences are needed.

In these sessions, the adult gives positive reinforcement and guides the student to see where changes are needed. Students take the original reports home to show their parents, and copies are kept at school. Sometimes a teacher attaches additional comments to a report. Parents write or call if they have questions, suggestions, or concerns.

OUTCOMES

Students' overall grades have improved. The child who uses the notebook has been writing most of the assignments in it and completing them on time.

Most important, communication among students, teachers, and parents has improved greatly. Many parents have expressed extremely positive feelings about the teachers, the school, and their child after seeing the results of the practice. Some teachers have expressed great empathy for the parents who are working hard to fulfill their obligations and follow through on the plan.

Because the students are involved in every aspect of the plan, the students and the parents feel that the practice has helped students succeed and has provided a point of reference for use in other situations.

REPLICATION

The essential element in replicating this plan is the willingness of staff, parents, and students to cooperate. Parents and students must agree in advance on the positive and negative consequences of the plan. Staff members must be open to taking a few extra minutes to help the students carry out their part of the plan. And parents must willingly and consistently follow through with the consequences of the plan.

The administration must allow staff the necessary time to meet with students, write the weekly progress reports, and (when required) check the assignment notebook daily. Teachers must be able to work with students, parents, and other teachers if problems arise during the week. Teachers should be flexible and caring, and they should clarify any questions the students may have.

Students must be involved and feel that they are an integral part of the planning, decisionmaking, evaluating, and adjusting that are involved in carrying out the plan. Success is more likely when the students feel that their feelings and thoughts are taken into account.

Finally, and most important, lines of communication must be open among all parties involved.

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Task Force for ADD
Baltimore County, Maryland

BACKGROUND

The public school system of Baltimore County, Maryland, has an enrollment of 89,700 students. A dedicated task force directs the county's program for educating everyone involved about ADD and improving services for students with ADD and their families. This program now includes educational materials and adult education classes.

In 1989, a member-at-large of the Board of Education met frequently with several parents of ADD children who were experiencing frustration with the school system. As a result, a task force was formed to focus on the critical need to educate parents, administrators, teachers, and students about ADD.

DESCRIPTION

In the next school year, the committee took several actions. First, it developed two brochures, one for teachers and one for parents, describing ADD and its characteristics, with tips for helping children with ADD be more successful and strategies to help parents and teachers work together. In addition, the brochure told what parents should do if they suspected their child had ADD. The parents' brochure was sent to all parents of school-aged children, and the teachers' brochure was sent to all teachers.

Second, school administrators were encouraged to invite knowledgeable school staff to provide building-based inservice programs to enhance awareness about the educator's role in serving students with ADD.

Third, the task force provided a series of classes for parents through the adult education program. Educators, parents, and community service providers such as physicians participated as trainers. Five 2-hour classes, one class per week, were presented on the following topics:

- Overview of ADD
- How to be successful in school
- Parenting tips
- Working collaboratively with school personnel
- Medical issues

And fourth, the task force also presented two workshops for community leaders.

In the future, the task force may produce one or more videotapes for students, parents, and educators.

OUTCOMES

Other surrounding school systems have become interested in Baltimore County's program and reviewed the practices that have been implemented in this system. Parents, educators, and the community appear to be more informed about ADD as a result of services provided in this district.

REPLICATION

To replicate this practice, administrators must support it conceptually and financially. Educators, parents, and community physicians must work together to enhance services to students with ADD. A task force composed of individuals from diverse experience and expertise must be committed to providing guidance to the work.

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Parents' and Educators' Training Program
Billings, Montana

BACKGROUND

This practice was developed in Billings, Montana, by a school psychologist working as a professional educator. It consists of two workshop series:

- One for parents, called "Working with Your ADD Child"
- One for educators, called "Understanding Attention Deficit Disorders: Assessment and Interventions"

The school psychologist was trained for developing and presenting the workshops by attending several professional workshops and conferences on ADD and learning disorders; researching books, articles, and videotapes; and interviewing with ADD students and their families.

DESCRIPTION

Parents' Workshop

The goals of the parents' workshop were as follows:

- To increase parental awareness of ADD and its treatment.
- To educate parents about the impact and importance of meeting the educational, psychological, and social needs of children with ADD.
- To increase parental knowledge of home and classroom behavior management techniques that are effective with children who have ADD.
- To educate parents about theoretical and practical education strategies.
- To explain effective, innovative ADD methods and materials that have been used successfully at home and at school.
- To provide information about agencies, current laws, and available literature.

- To provide information about an opportunity for interested parents to form their own independent, nonprofit chartered organization dedicated to meeting the education, social, and emotional needs of ADD children and their families.

The parents' workshop is presented in four weekly sessions of 2 hours per session.

Because the support of districtwide school administrators was important to the success of the parents' workshop, the school psychologist attended a staff meeting of administrators to brief them on the workshop and the need for it. The school psychologist gave each principal a complete packet of handouts and references.

Several methods of reaching the parents were used:

- A letter of invitation was printed in the parent newsletters of each of the city's elementary schools.
- School administrators and teachers with students who had or might have ADD were asked to call parents of those students with an additional warm invitation to attend. In addition, many teachers volunteered to attend with the parents.
- Notices were sent to the local newspaper and radio stations and the three local television stations.
- Fliers were sent to pediatricians, private counselors, college campuses, and mental health centers.

The school psychologist was the primary speaker for each program. A video, developed by Dr. Edna Copeland, a national expert on ADD, was used in each program. Also invited to speak about their insights and recommendations were a resource room teacher, a pediatrician who specializes in ADD, and a high school student with ADD. Printed handouts summarizing the main points of the presentation were provided for all the attendees so they would have written material to take home and review. Two parents assisted by registering parents and displaying available books and materials on ADD.

To help pay for some of the research and preparation time, materials, refreshments, and baby-sitting services, a minigrant was obtained from the school district.

Educators' Workshop

This indepth, graduate-level workshop was designed to equip educators with a comprehensive understanding of ADD as well as an extensive menu of effective strategies to ensure confident and successful intervention with students who have ADD. Lecture, active participation, textbooks, handouts, and video presentation are used.

When presented in 15 hours during a 3-day weekend, the program carries one semester of college graduate credit at the local college. It could be presented as either a graduate or an undergraduate course, and it has been presented as a teacher inservice program.

After course approval was obtained through the college, fliers were sent to all alumni and all school district educators. For maximum interaction and participation, the class size was limited to 25. However, for teacher inservice use, the material has been adapted and presented to more than 150 teachers in a half day.

One educator could present the course, but rich insights and variety are added when a pediatrician, a student with ADD, a resource room teacher, and the parent of a child with ADD participate as guest speakers.

The following topics are covered:

- History and causes
- Assessment and diagnosis
- School evaluation
- Medical evaluation
- Medical management
- Educational interventions
- Behavior management
- Psychological interventions

- Developmental stages
- Innovative methods of parenting
- Family issues
- Current educational laws and policies
- Available resources

OUTCOMES

Parents' Workshop

More than 300 parents attended the first workshop series, and more than 150 others asked for a repeat performance. Since that first presentation, this program has been presented to more than 500 teachers and parents through inservice days, PTA meetings, and other parent group meetings. Several requests have been made for future presentations.

The workshop created an awareness, an understanding, and an acceptance of ADD. Parents who attendees saw that attention deficits are real and that there is help and hope for the child with ADD, for the family, and for the school. Equally important, they learned that they are not alone.

Nurses and doctors who attended realized how often ADD is a family problem that affects each member and that a child need not fail academically before ADD is seriously considered as a possibility.

In addition, there was a positive response for establishing a parent support group, because Montana is a rural state with little opportunity for speakers, programs, and contacts. After a search for an appropriate national link, the organization Children with Attention Deficit Disorder was chosen. More than 200 parents and professionals from the school district have begun attending regularly scheduled meetings.

Educators' Workshop

The course was presented three times in one year to a total of more than 400 teachers, counselors, speech clinicians, social workers, and Native American tutors. Attending teachers and college officials were enthusiastic about the course, and college officials are considering including a basic course on ADD in the core requirement for all education majors.

Teachers went back to the classroom armed with practical ideas to help their students with ADD. They no longer took it personally when these students could not focus on tasks and finish them. Teachers appear to be taking closer looks at children, and principals are encouraging their staff to learn more about ADD.

The abbreviated half-day inservice version has also received very positive evaluations; word-of-mouth recommendations have resulted in several more invitations for inservice presentations, many from out of town. (Because of the size of the state and the sparseness of the population, few school districts in Montana have had an opportunity for training in this field.)

REPLICATION

Parents' Workshop

With appropriate training, any professional educator can replicate this workshop. The educator should work closely with fellow educators or parents who either have ADD or have a child with ADD. This personal affiliation adds credibility and creates a bond with the parents.

This practice has been shared with parents of preschoolers as well as parents of elementary, middle school, and high school students. The overall framework is appropriate for all parents, but classroom interventions and parent strategies must be tailored to the age of the student.

Once the initial purchases have been made, maintenance costs are low. An overhead projector and a videocassette recorder with a large television screen are the only necessary equipment. Each school or agency that requests a presentation can be asked to prepare copies of the handouts and provide space for the program. PTA's, local service agencies, and churches have often requested this presentation, and they make excellent resource supports.

Educators' Workshop

The very flexible format lends itself to a basic overview (2-hour minimum), a half-day inservice, or a full 15-hour graduate class (one semester credit). By identifying the specific needs of the target audience, the presenter can fine-tune the emphasis of the presentation.

The various formats can be presented at local schools. The basic cost of presenting the course is simply the duplication of handout materials. And to students taking the course at the graduate level, there would be a per-credit cost.

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Staff Development Program for Teachers
Reno, Nevada

BACKGROUND

A school psychologist designed this inservice class for teachers in the Washoe County, Nevada, school system and presents it as a collaboration among teachers in which they develop interventions for use in their schools.

The focus of the practice is that effective learning opportunities occur when there is positive interaction between the child and everything going on around the child at home and at school — the demands, the expectancy, and the supports.

The practice was designed to supply teachers with the three types of knowledge they need so that they can foster positive interaction between students and their environment:

- Understanding ADD
- Practical information about common classroom intervention strategies
- Understanding of the child and the child's social environment

DESCRIPTION

In the class, emphasis is placed on how a child's ability to focus attention contributes to the learning process, and current neuropsychological theories about ADD are presented. Most of the class time is spent developing strategies to manage the behavior and increase the learning of children with ADD.

The practice has goals and objective in five areas.

Goal 1. Increased knowledge about ADD. It has been shown that teachers who understand ADD as a biologically based handicapping condition are more likely to use and persevere with recommended interventions.

Objective 1. That participants be able to demonstrate knowledge of the basic biological, sociological, and psychological facts about ADD.

Goal 2. Increased understanding of family issues involved in raising a child with ADD in order to better foster collaboration between home and school. Home-school collaboration is essential in many effective educational interventions. Parents can support strategies that are working in the classroom and tell the teacher about strategies that are working at home. For this collaboration to develop, however, parents and teachers must communicate their experiences to each other.

Objective 2. That participants hold a panel discussion between parents and teachers, before an audience of teachers and parents. From such a discussion, parents and teachers can develop techniques such as a system of daily reports between home and school or other management plans that involve both the family and educators.

Goal 3. General understanding of classroom behavioral interventions that may help manage behavior and productivity. Teachers' attitudes and techniques are significant factors in how well students with ADD succeed in the classroom.

Objective 3. That participants be able to describe the type of attitude that is most successful with ADD children, to develop an effective "behavior contract," to describe many of the classroom modifications necessary with ADD children, and to learn to focus on student strengths when developing education plans for students.

Goal 4. Acquisition of skills necessary for developing behavior management plans for various types of behavior problems. Certain methods that are based on learning theory and are known as behavior management techniques can be used with most students regardless of their type of behavior deficit.

Objective 4. That participants be able to demonstrate basic knowledge of behavior management techniques, develop a list of positive reinforcers to use in the classroom, and develop a behavior management plan for a child with ADD.

Goal 5. General understanding of medical interventions used to help children with ADD. Considerable research indicates that a combination of behavior modification techniques and stimulant medication treatments is superior to either treatment alone. Teachers must understand the basic principles of medication interventions for children with ADD, because so many of these children are on drug therapy. They also need to understand that medication does not cure the ADD problem but, rather, often allows other interventions to work. Teachers also must learn how to monitor the effects of medication on children in their classrooms.

Objective 5. That participants be able to demonstrate knowledge of basic principles of medication therapy and to discuss classroom monitoring strategy for ADD children on medication.

OUTCOMES

In evaluations by participants, superior scores were given to class organization, presentation style, information learned, and interest level of the material. The panel discussion was mentioned frequently as a highlight of the class.

An unexpected outcome of the inservice was the comment by five participants that the class would be helpful for teachers of all students. Participants specifically mentioned the behavior management techniques, the *1-2-3 Magic* discipline strategy, and the high-interest curriculum as tools that would be useful with all students.

Many schools in Washoe County are now equipping their child study resource libraries with the manual used in this class.

REPLICATION

This inservice class could easily be replicated at other school sites. The manual used is available from the school system. It is recommended that the class continue to be taught as a collaborative venture among teachers and parents.

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Homework Strategy
Boardman, Ohio

BACKGROUND

To enable students to become better organized about their homework assignments, a learning disability teacher developed this practice. This homework strategy makes students and parents more aware of homework assignments to be completed and increases communication between home and school. It has been used successfully with students in elementary and middle school special education classes who are mainstreamed for a portion of the day.

DESCRIPTION

Each student who needs help organizing homework assignments is given an assignment sheet. The assignment sheet lists each subject and provides a space where the student answers clearly, yes or no, whether the homework was completed. Near the end of each class, when homework assignments are being given, the student or the teacher writes the assignment on the assignment sheet, using as much or as little detail as needed.

Students who write their own assignments verify the accuracy of what they have written with a peer or the teacher. In addition to the end-of-class checks, the student's assignment sheet is routinely reviewed at least three times a day by either the homeroom teacher or the resource room teacher. The first review is done first thing in the morning. All homework is checked for completeness — for example, if 10 math problems were assigned, 10 problems should be complete.

In addition, sheets are checked in the morning for a parent's signature, which is a nightly homework assignment in itself. At first, even when there are no assignments, the form must be taken home, signed by a parent, and returned the next morning. The signature process is an incentive: when a student receives an "S" (satisfactory) in homework in all subjects, the signature line is removed and the student no longer has to show the paper to his or her parents every night.

The second review is at noon, and the third, at the end of the day, is for making sure the student has written down all the assignments and has the materials that are necessary to complete them. The number of reviews is decreased when the student demonstrates independence in completing assignments. Usually the student makes this judgment, but the teacher may do so when necessary.

Students and parents agree in writing that uncompleted homework will be finished at school, in "homework class," on the student's time; parents agree to furnish transportation when students miss the bus on account of homework class. (When necessary, other arrangements for homework class can be made, such as during a lunch period.) An evening of homework class is incurred by leaving homework incomplete twice in a 10-day period. The students monitor their own homework completion, tallying on a calendar in their notebooks their yes and no answers on the assignment sheets about homework completion.

OUTCOMES

The homework strategy has helped the students become more responsible and honest. Having to answer clearly yes or no each day to the question whether homework was completed has eliminated a formerly gray area, and students have become more willing to accept that work is either complete or not complete.

Learning problems have become easier to discern, and the students are more willing to indicate lack of understanding about homework assignments before they go home. Not knowing how to complete an assignment is not considered a valid excuse for not completing it; consequently, students want to understand the assignments before they leave school for the day.

Many of the students see three, four, or five teachers per day. Teachers in mainstreamed classes have become more aware of the amount of homework assigned by their partner teacher.

Communication between the home and the school has increased greatly. Teachers frequently jot quick notes on the assignment sheets that are headed home, and parents often respond as they are signing. The question "Why doesn't my child ever have any homework?" is asked rarely now.

REPLICATION

The homework practice can be easily replicated in the regular program when students have a core teacher or case manager to report to throughout the day.

Administrative support is needed in arranging after-school homework classes. Parents must be engaged in this process, because they commit to checking homework daily and providing transportation to homework class when necessary.

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ADD Partnership of Ohio
North Canton, Ohio

BACKGROUND

This practice was developed by the ADD Partnership of Ohio, a nonprofit, tax-exempt parent organization staffed entirely by volunteers. The ADD Partnership of Ohio was organized in December 1986 for parents, educators, and professionals seeking ways to learn and understand children and families living with ADD. Most of its more than 400 members are concentrated in a four-county area.

This group took the lead in developing a positive and collaborative relationship with the schools and community service agencies in serving students with ADD. In the group's approach to ADD, short- and long-term goals are directly connected to a basic philosophy of advocacy for students with ADD. Positive communication among parents, educators, medical professionals, and related disciplines are stressed rather than "quick fix" ideas and "tear down the door" methods for educating children with this disorder.

The following five priorities were delineated:

- Education and support of the family
- Education and support of school personnel and educational systems (prekindergarten through postsecondary)
- Education and support of the relevant professional community at large
- Education and support of, and collaboration with, interested community service agencies
- Education and collaboration with area universities and colleges in regard to training future educators

DESCRIPTION

Programs and services are delivered and materials are developed entirely by volunteers, who receive no compensation other than reimbursement for expenses. Members of the board of directors and chairs of the committees are all volunteers and parents of children with ADD.

In addition, a volunteer professional advisory board is available as a resource but has no voting privileges regarding organizational activities or policy. Several local organizations such as the Junior League and United Way have assisted the ADD Partnership in accomplishing its goals.

The ADD Partnership offers the following services:

- Printing and distributing monthly newsletters.
- Arranging group meetings to raise awareness about ADD.
- Printing and distributing informational handouts about ADD.
- Creating and staffing a phone line to handle inquiries about ADD.
- Developing and distributing parent and teacher packets in response to requests.
- Developing and distributing the *ADD Handbook*, which is available from the organization.
- Providing parents, schools, and other community groups with reasonably priced audiotapes and videotapes of meetings, conferences, workshops, and inservices.
- Providing speakers and materials for school inservice or other community presentations.
- Making arrangements for special workshops and conferences that are accessible to families, school personnel, and the community.
- Conducting parent training and support groups.
- Participating in local, regional, state, and national educational organizations, governmental associations, and policy development forums on behalf of children and families living with ADD.

Parents involved in the ADD Partnership are educated about attention disorders as well as about the structure, function, and protocol of the organizations they are involved with — schools, parent-teacher groups, civic associations, and so on. Services offered are carefully evaluated for relevancy, quality, and effectiveness so that they will be viewed as helpful rather than intrusive.

OUTCOMES

Results of these activities have been encouraging. Several events in recent months have indicated continued promise for organizational goals and objectives:

- Grant monies awarded to ADD Partnership of Ohio by the local United Way Agency are making it possible to develop two new programs, one for parents of adolescents and one for adults with ADD. Both programs are developmental initiatives that will require considerable planning. Both will have cofacilitators, one of whom will be a parent.

- The collaborative approach with area schools is resulting in better communication and development of projects. For example, recent discussion with one school system has resulted in the development of an awareness and education program that will be applied throughout the entire school system.

- Increased awareness as a result of involvement with area universities and colleges is creating an environment for sharing and exchanging resources and ideas and for developing collaborative programs. Consideration is being given to including attention disorders and related subjects in the teacher preservice curriculum.

- The President of ADD Partnership of Ohio received a 3-year appointment to the Ohio Governor's Council on People With Disabilities, a state-level forum where the educational, developmental, and social concerns of children with ADD can be heard.

REPLICATION

To replicate this practice, the community must have a positive, proactive parent group that will take the lead in facilitating service for students with ADD. To accomplish the goals, everyone involved must recognize ADD and accept it as a disability. The activities initiated by the ADD Partnership of Ohio may act as a springboard for ideas other communities could model.

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Student Organizational Strategy:
"Your Notebook Should Look Like This"
Drexel Hill, Pennsylvania

BACKGROUND

A middle school teacher in Drexel Hill, Pennsylvania, found a way to help his students get organized. This strategy was used in a heterogeneously grouped regular classroom of 28 students. The class had seven students with special needs, such as ADD, and the ability of the students ranged from low average to superior.

DESCRIPTION

In the sixth-grade geography class various handouts are used for assignments rather than the textbook. Students, especially the ADD children, find it difficult to keep these papers organized, so the teacher shows them what their looseleaf notebooks should look like.

On the geography bulletin board is an area headed, in large capital letters, "Your notebook should look like this." When beginning a new unit, the teacher posts a table of contents page on that area of the bulletin board. As each assignment is written on the chalkboard, a copy of the worksheet is placed on the bulletin board, numbered, and listed in the table of contents. All the students keep a similar table of contents in the front of their notebooks.

Not only does this simple strategy show the students how to organize their assignments and their notebooks, it has several other useful functions:

- Students who were absent can see at a glance what they have missed so that they can complete their assignments and their notebooks.
- When a unit ends and a test is given, students hand in their notebooks to be graded.

- When work is poorly done, a copy of the table of contents can be sent home to a parent with missing or incomplete assignments checked off.

OUTCOMES

Students have greatly benefited from this organizational strategy. They know what to expect, and the support is provided so that students with ADD can be successful.

As a form of communication, this practice helps parents gain confidence in their child's teacher; they feel better knowing that there is a concrete homework system in force and that they will be informed quickly if their children are not doing their assignments. Parents of children with ADD have responded positively to the practice.

REPLICATION

Costs and materials for this practice are negligible. It can be used with a wide range of middle school students. Even though it was devised for a geography class, it could be modeled in any class that requires an organized notebook. This strategy may also hold promise for secondary-aged students.

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Tic-Tac-Toe Revisited
Sandy, Utah

BACKGROUND

This practice, a variation of the old tic-tac-toe game, was developed by a school psychologist in Sandy, Utah, working in an elementary school setting with open classrooms. This mainstream intervention helps ADD students learn to complete tasks while doing independent work.

The primary goal of the practice is to increase the student work productivity, a goal that has several benefits:

- Increase in independent work completion
- Reduction in disruptive behavior
- A measure and sense of success for the teacher
- A sense of academic progress for the student
- A sense of social acceptance and status for the student

DESCRIPTION

The tic-tac-toe game consists of

- specially made tic-tac-toe cards,
- tokens,
- reinforcements, and
- charts for recording progress.

The tic-tac-toe card is an 8 ½- by 11-inch card with nine pockets for holding the tokens. Each of the nine pockets and the nine tokens is labeled with one letter from A to I and with a number from 1 to 9. The object of the game is to place three tokens in their pockets across, down, or diagonally (there are eight possible ways of achieving tic-tac-toe).

The number on the token represents how many units of work must be accomplished before the token can be placed in its pocket. For example, the number may represent a number of problems or rows of problems to be completed or a number of pages to be read, and so on. The teacher has the flexibility of adapting the game to many different types of academic tasks, and any task can be broken down into separate, manageable work assignments for the student. The teacher can also number the tokens differently to suit the individual situation.

Here is how the game is played: The tokens are placed in an opaque container (in the original practice a shoe box with a slot cut in the top large enough to admit two fingers was used). The student blindly draws one token. If the student draws a token for a space that has already been filled, the student draws again. The student's task then is to complete the amount of work indicated by the number on the token. Once the work is completed, the student places the token in its pocket on the tic-tac-toe card. The student can keep selecting more tokens until either the work period expires or a tic-tac-toe is achieved.

When a tic-tac-toe is achieved, the student raises his or her hand and waits for the teacher to help. The teacher checks that the student completed the work corresponding to the tokens and may also check for accuracy. When work is broken down into small steps, it may be more practical for teachers to inspect the cards after the work session is completed rather than after each tic-tac-toe is earned.

Students can earn more than one tic-tac-toe at a time. In fact, if the center space, the E space, is the last one filled, four tic-tac-toes may be simultaneously earned.

REINFORCEMENTS

To make the earning of a tic-tac-toe meaningful to the student, each tic-tac-toe earned brings the student one step closer to gaining a reinforcement, that is, a reward that intensifies the students' feeling of accomplishment. Reinforcements take into consideration students' interests and can include such things as a sheet of stickers, plastic bugs, a soft drink, extra minutes of recess, or computer time.

To keep motivation up for earning reinforcements, and to show the students' level of progress graphically, charts are used. The two most commonly used in the original practice were the ***Dot-to-Dot*** and the ***Magic Grid*** charts.

The Dot-to-Dot charts are dot-to-dot pictures taken from children's activity books, which can be purchased at toy stores. Each time the student earns a tic-tac-toe, another dot is connected.

Various dots are color highlighted in advance to designate them as reinforcement points. For example, dots number 10, 20, 30, 40, and 50 might be highlighted, each in a different color, and the reinforcements might be listed on the back of the picture. In addition, when all the dots have been connected, a bonus prize of greater reinforcement value may be earned. The teacher can adjust the frequency of the reinforcement schedule by selecting as reinforcement points dots that are closer or farther apart.

The other technique, the Magic Grid, is a nine-space grid with the numbers 1 through 5 listed at the top of each space (the teacher can add more numbers at will). In each space, the teacher has written a reinforcement with an invisible marker (usually available where toys or school supplies are sold). The student randomly selects a space on which to begin tallying the tic-tac-toes earned. After each tic-tac-toe is achieved, a number is crossed out in that space on the Magic Grid. When all of the numbers have been crossed out, the space is colored in with a colored marker. The colored marker reveals the hidden message and the student receives the reinforcement. This surprise element seems to add greatly to the students' motivation to earn the tic-tac-toes.

It should be mentioned that these charts can be used without the tic-tac-toe game. For example, students could simply cross out a number on the Magic Grid for every completed math page.

Group reinforcements or a combination of individual and group reinforcements are suggested for students in grades four through six, who are more sensitive to social pressures. The *Stairway to Success* chart was designed for use with group incentives. The "stairway" has 10 steps. For each tic-tac-toe earned, the student advances one step until the 10th step is reached. The student's progress can be marked with stickers, stamps, or paper figures, and so on. (One teacher used a paper cutout of a cheerleader and moved it up from step to step.)

When the student reaches the 10th step, the entire class chooses a reinforcement from a menu of reinforcements compiled by the teacher. The reinforcement value is even greater if the class is permitted to make suggestions about the content of the reinforcement menu.

Another way to increase class involvement is to have the student select a classmate to choose the reinforcement. (Favoritism must be avoided.) If this technique is used, the student should be permitted to do the choosing every so often (every fixed number of reinforcement events), to keep motivation high.

In addition — if a combination of individual and group reinforcements is desired – the student who gets to the top step of the "stairway" may be permitted to select an individual reinforcement from a separate reinforcements menu compiled by the teacher.

OUTCOMES

The tic-tac-toe practice has several advantages for students with ADD:

- Classwork becomes a game, which increases student motivation.
- Work is broken down into separate units, which reduces students' feelings of being overwhelmed by the task demands.
- The visibility, immediacy, and frequency of the reinforcements help to counter the inattention commonly associated with students with ADD.
- Students' self-esteem is enhanced as the student makes progress on the charts. (This sense of accomplishment is infrequent for students with ADD in mainstream classrooms.) Because this practice breaks down into manageable units and offers frequent reinforcements, even small improvements can be monitored and observed.
- Teacher-student conflicts are reduced. Because the tic-tac-toe tokens — not the teacher — dictate the work to be completed, conflicts are minimized. This appears to be especially true for oppositional students with ADD and students who have developed a negative relationship with their teacher.

Three unexpected benefits have also come from the tic-tac-toe practice. First, students troubled by associated disorders such as depression or school resistance have improved. Second, students' sense of frustration has been greatly reduced, because the focus is on what they are accomplishing rather than what they are not accomplishing. This emotional relief has moderated students' physical complaints. And third, using group reinforcements may result in greater acceptance of the ADD students by their classmates.

Most students with ADD are bothered by poor peer relationships; their peers associate them with negative outcomes. The Stairway to Success technique leads to alterations in classmates' perceptions, because — frequently for the first time — classmates associate the ADD student with positive outcomes, and the student acquires status. This increased acceptance by peers may have a snowball effect on the other benefits that have been mentioned, and it may even improve behavior at home.

REPLICATION

Using the tic-tac-toe practice involves relatively little cost in terms of materials and training. Besides the cards and tokens, the only other materials needed are the reinforcements, which greatly enhance the incentive value of the program. In the original practice, parents provided all the reinforcements up front. This approach seemed ideal, because the parental involvement was a plus, and the school's cost was reduced.

Virtually no teacher training is required. The most important points for the teacher are to be consistent in monitoring the work completed and to help the students remember to mark their progress on the charts.

The tic-tac-toe practice could be used with elementary students in either open or closed classrooms, and it is easily adapted to special education classrooms, too.

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Six-Step Education Program
Kenosha, Wisconsin

BACKGROUND

In the 1990-91 school year, Kenosha Unified School District had 9,030 students in its 21 elementary schools, of whom 3 percent, or about 270 students, had a diagnosis of ADD. Of those 270 students, 72 percent were in regular education and 74 percent were on medication. Prompted by these findings, Kenosha Unified developed a six-step plan for identifying, evaluating, and providing services for ADD students in the regular education setting.

This practice was developed to:

- provide a consistent method of identifying and serving students with ADD,
- implement strategies and interventions in the regular education setting,
- develop an education plan for each ADD student,
- increase teachers' awareness and knowledge of ADD, and
- provide teachers with strategies for intervention.

DESCRIPTION

The components of the Six-Step Education Program are coordination, the individual Attention Deficit Education Plan, staff development, assessment, counseling, and communication.

Coordination

Because of the size of the school district and the proportionately large number of students with ADD, the new position of ADD program consultant was created to coordinate the ADD program. Otherwise, existing staff were sufficient. The ADD program consultant has the following responsibilities:

- Coordinating and monitoring the Attention Deficit Education Plan (ADEP) of each student with ADD to ensure that the educational needs of all the students with ADD are being met.
- Tracking the students with ADD within the school district from year to year.
- Sending notices to teachers identifying students with ADD and explaining that their ADEP'S must be completed by October 31 and reviewed by May 31 of each school year.
- Assisting teachers in developing teaching strategies and interventions.
- Providing technical assistance and support to staff in writing and carrying out individual education plans.
- Acting as a liaison to parents, physicians, and teachers to advocate for the needs of the child.
- Providing the district's inservice training on ADD assessment and intervention.

The Attention Deficit Education Plan

Once a child has been diagnosed with ADD, an ADEP is developed for that student by the teacher and the school counselor in collaboration with the family. The ADEP identifies desired behavioral goals along with the teaching strategies and interventions that will be used to achieve the goals.

The strategies and interventions are defined very specifically so anyone reading the ADEP will know exactly what is happening at school. For example, if the desired behavior is "Johnny will remain on task," some strategies might be to reinforce suitable task behavior with praise or tangible rewards such as classroom privileges, passing out materials, 5 minutes of free time, or computer time. Examples of other strategies might be to:

- provide frequent, immediate feedback;
- establish clear, simple classroom rules and restate them often;
- communicate with the parents on a daily progress note and allow the parents to provide the reinforcements;

- redirect the student;
- develop a secret signal that cues the student to get back to work; and
- reduce auditory and visual distractions.

At the end of the school year, the teacher reviews the ADEP and records comments for the student's next teacher (the "receiving" teacher), such as what techniques worked and did not work, effective reinforcers, and recommendations. The receiving teacher develops a new ADEP by October 31. The teacher and the school counselor then meet with the parents to discuss the plan and address any parental concerns.

Staff Development

Staff inservice training about ADD was done to help teachers and other staff develop knowledge, skills, and strategies for dealing with ADD behaviors. Both districtwide training and job-specific training were done.

Sixteen hours of ADD training were added to the ongoing districtwide training for regular and special education teachers, school psychologists, social workers, counselors, program support teachers, speech therapists, and other educational support staff. These 16 hours included lecture and discussion on characteristics of ADD, causes, treatment, teaching strategies and interventions, behavior management, and communication with parents and physicians.

The ADD program consultant modeled teaching strategies and behavioral interventions to demonstrate how these techniques can be implemented easily and efficiently. Participants were given case studies and practiced developing and writing an ADEP. They developed simple and complex behavior management programs and explained how to use them in their classrooms. Teachers were encouraged to start with a simple management system and expand as their comfort level increased.

The school psychologist and social workers were given job-specific inservice training on scoring evaluation tools and interpreting the findings. They were given an opportunity to practice as a group, discuss, and ask questions. They learned what to look for when taking a social medical history and reviewing the child's school records. School counselors received inservice training on techniques such as social skills training, anger control, frustration management, self-talk for impulse control, and problem solving. The ADD program consultant was available for consultation later in case questions or problems arose.

Various behavior management techniques were modeled and taught. For example, one simple management technique is "Good Slips," which are given to all students in the class to reinforce desired behavior. Any student who receives a certain number of "Good Slips" within a certain time earns a reward, such as 5 extra minutes of recess. Those who earn more than the required number of slips for extra recess place them in a grab bag, and the teacher draws one. The student then receives a special treat.

Teachers were encouraged to post clear, simple classroom rules for behavior and review them frequently. Other techniques included:

- self-monitoring,
- self-reinforcement,
- writing contracts,
- providing frequent feedback to students,
- using visual or auditory cues as reminders,
- control by proximity, and
- letting students choose activities.

Examples of more complex behavioral strategies are a response-cost system that provides consequences for both appropriate and inappropriate behavior, point systems, and daily progress notes linked to parental reward systems at home.

Regular classroom teachers learned about the following:

- Presenting lessons to ADD students
- Placing ADD students in an effective room arrangement
- Modifying class assignments and tests
- Devising organizational strategies for the classroom

Some specific academic modifications were suggested:

- Reducing the amount of work the student is required to do
- Using a marker to highlight instructions or key concepts
- Giving only one assignment or worksheet at a time
- Placing borders around paper to help the student focus on the paper
- Using graph paper for math to keep numbers lined up
- Making sure worksheets are uncluttered
- Color-coding assignment folders to coordinate with textbooks

Assessment

Because understanding and accepting the problems of the student is a very important first step in the intervention process, the assessment portion of this practice is crucial. The evaluation is done by a team coordinated by a school psychologist and a school social worker. If medical evaluation is thought to be needed, the school may consult with the family about ways of obtaining that service. In this way, medical problems are ruled out and the need for medication is assessed.

Kenosha Unified's assessment process is described in a document called "ADD Assessment," which is available from the school.

Counseling

The school counselor may intervene with a student with ADD in a variety of ways depending on the need identified by the parents, the teacher, the school psychologist, the social worker, or the physician. These are some of the ways school counselors can serve children with ADD:

- Doing individual or small group counseling.
- Making classroom presentations on topics such as "being a friend."
- Modeling interventions in the classroom — for example, showing the teacher and the students how to solve problems by using specific methods such as the "Stop-'n-Think" technique.
- Assisting parents with information or acting as liaisons to community agencies.

Communication

Communication is one of the most important components of intervention with students with ADD. Communication with parents, which is considered crucial in this program, is typically initiated by the teacher and the counselor. Parents are involved every step of the way from beginning-of-the-year conferences to development of ADEPs. The school is sensitive to parents' schedules; school personnel make a point of asking parents what the best times are for conferences and telephone calls and how the school can best contribute to a cooperative home-school relationship.

Communication with the physician is made easier by using two forms, *the physician evaluation* form and the *medication followup report.*

Physicians to whom a child is referred are asked to complete a physician evaluation form, which asks for the following information:

- The child's diagnosis
- Medication prescribed
- Dosage time
- Need for further evaluation
- Other diagnosis and treatment

For children on medication, the teacher completes a medication followup report and sends it to the physician 2 weeks after medication is started or dosage or medication is changed. A copy is sent to the parents. On this form the teacher checks off any side effects any that have been noticed. Other questions on the form concern fluctuation in behavior throughout the day, attentiveness, impulse control, and physical activity level. The teacher checks off how the student is doing academically and socially. Additional space is provided for other concerns.

OUTCOMES

Physicians are responding positively to receiving thorough ADD evaluations and being consulted by the ADD program consultant by telephone. The ADD consultant was invited to speak with a group of local pediatricians to explain the district's six-step ADD program and define what the school expects of physicians when students are referred to them. Another group of family physicians asked the ADD consultant to speak with the doctors in their clinic. In these ways, many local physicians have become more aware of ADD, how it is treated, and how they can participate as team members with the school to help children with ADD become more successful.

Parents have expressed their appreciation that a method has been developed for meeting the needs of their children. In addition, parents have identified the need for a local parents' support group.

Subjective teacher and parent reports indicate increases in the students' self-esteem and improvements in relationships with teachers and peers. It is too early to assess the academic ramifications, but it is believed that early identification and intervention will reduce risk of failure and increase academic success.

The response to inservice training has been overwhelmingly positive from teachers and support staff.

REPLICATION

Kenosha Unified's approach could be used in either large or small school districts. Some additional staff may be needed for the evaluation function. Also, an ADD consultant or coordinator is necessary to ensure that practices are consistent among the staff who do the ADD evaluations and the teachers and counselors who provide the interventions. Except for the new position of ADD program consultant, Kenosha Unified is doing the ADD work with existing staff.

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School-Based Collaborative Assessment
Sturgeon Bay, Wisconsin

BACKGROUND

Ten years ago the assessment of children with ADD in the Sturgeon Bay School District was done case by case, primarily on the basis of a private physical examination. Today a systematic process is in place for identifying and following up with children with ADD in this rural kindergarten-through-12th-grade district of 1,500 students. Implementing the process involved forming a collaboration among school personnel, parents, students, physicians, and the community.

DESCRIPTION

A core team of participants consisting of a local pediatrician, a school psychologist, a school counselor, and a special education teacher worked on this project. The core team exchanged research, publications, and observations and made recommendations for a systematic assessment process that would lead to early identification and intervention of students suspected of having ADD.

It became apparent that effectively implementing the team's recommendations meant the following had to be performed:

- Help staff, parents, students, physicians, and the community become aware of ADD and its effect on the educational process.
- Establish a consistent approach for identifying and assessing children with ADD.
- Encourage active parent and home involvement.
- Establish consistent followup.
- Facilitate networking among community resource.

- Arrange staff inservices
- Include a series of articles in the local newspaper and school newsletters.
- Rebroadcast staff inservices over cable channel.
- Provide individual conferences through the guidance department staff.

Consistent Approach and Parental Involvement

Establishing a consistent approach to identifying and assessing children with ADD necessarily involved encouraging family involvement, and so a procedure was put in place to facilitate collaboration between home and school. During the entire process, the teacher and the parents continue to monitor and revise the intervention plan as needed to help ensure the child's academic and personal success.

The assessment process consists of the following steps:

- *Observation by the classroom teacher.* Typically the child's classroom teacher is first to notice the child's lack of success with school assignments or problems with peer relationships. The specific behaviors noticed might include failing to finish work, seeming not to listen, appearing easily distracted, having difficulty organizing work, speaking out frequently in class, requiring close supervision, having difficulty sitting still, fidgeting, and bothering classmates.

- *Review of behavioral records file.* The teacher's first action is to review the child's behavioral records file, where information is found about any previous school testing, general health, and any previous physical concerns such as vision or hearing. The record shows whether the problems that have been noticed are chronic.

- *Consultation with parents.* The teacher then consults with the parents. (Sometimes, however, the parents initiate these consultations, because they want to know if behaviors they have noticed at home are also apparent at school.)

- *Referral to health professionals.* Parents and teachers determine together whether there is any possibility of vision, hearing, or health problems. To rule out such problems, referrals may be made to the Public Health Department, a vision specialist, a hearing specialist, or the family physician.

- Plan for interventions. The parents and the teacher might also develop a plan of interventions to deal with the problem behavior, such as preferential seating, a homework "contract," or a daily home-school notebook.

- *Consultation with other school personnel.* At this point, the teacher and the parents often request consultation with the guidance counselor, the psychologist, or the special education teacher. New interventions may be introduced and tried. The possibility of doing pertinent evaluations is discussed – for example, assessments of academic learning, speech and language development, emotional and behavioral development, fine and gross motor development, or a complete psychological evaluation.

- *The ADD assessment.* The ADD assessment typically includes the following:

  - *One or more classroom observations by a neutral observer.* During observation, the child's on- and off-task behavior is noted and compared to that of an average peer.

  - *Completion of various questionnaires by the teacher and parents.* Questionnaires typically used are the Conner's Questionnaires, the Achenbach Child Behavior Checklists, and the Barkley Home-School Situations Questionnaire.

  - *A psychological evaluation* (when necessary and the parents consent). The child's abilities, strengths and weaknesses, achievement levels, and social-emotional development are assessed.

- *Implementing the assessment.* An analysis of the assessment is shared with the parents and the teacher. The current plan of intervention is reviewed, recommendations are made for additional regular education program modifications, and exceptional education programming is recommended as needed.

- *Referral for further diagnosis.* If appropriate, the school staff refers the child and parents to their family physician or pediatrician for further evaluation and diagnosis. Parents are asked to sign permission forms for the exchange of information between school personnel and the physician. Copies of all assessment information, intervention plans, and school records are sent to the physician before the child's appointment.

Followup and Monitoring

Two weeks after a student starts medication or any change in medication or dosage is made, a *follow-up report on medication therapy* is completed. (This report is done quarterly on all medicated students.) Copies of the report are sent to the physician, the parents, and the guidance counselor, and a copy is put in the behavioral records file.

Two weeks into the new school year, the teachers complete the ADD followup report on medication therapy and give it to the guidance counselor for analysis. After analysis, copies are placed in the behavioral records file and given to the parents and the physician.

Networking

To facilitate networking with community resources, the school maintains contact with community health professionals. Written materials are shared, and professionals are invited to participate in and lead inservice training programs. They are consulted individually and in groups about the school's procedures for dealing with ADD.

OUTCOMES

Ten years ago, the Sturgeon Bay School District's ADD assessment was based primarily on a physical exam. Now, however, it is based on a collaborative model in which the medical community, school, and family work together in identifying and treating children with ADD.

The followup plan provides for better communication among the school, family, and medical community regarding ongoing intervention strategies. The followup report on medication therapy provides information at regular intervals to the physician in order to adjust for medication needs.

The developmental guidance counselors have now broadened the classroom unit titled "Individual Difference" to include information on ADD.

REPLICATION

Although the practice has been used at all levels, kindergarten through 12th grade, most referrals are at the elementary level. The ability to replicate this practice is not limited by district size or building level.

A core team must be established, and the team members' training and release time for planning the assessment procedure must be provided for. When the procedure is developed, inservice training must be provided for teachers and support staff.

Implementing the assessment procedures requires materials such as forms, pamphlets, videotapes and updated assessment tools.

Maintaining a quality program requires current information about ADD issues and research through workshops and college coursework.

For more information contact:
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Sturgeon Bay School District
Sturgeon Bay, WI 54235
(414) 746-2800

STAKEHOLDER CONSULTANT PRACTICES

Parent Training at Iowa State University
Ames, Iowa

BACKGROUND

Iowa State University is conducting parent training for families of children with ADD using a modified version of the program outlined in *Defiant Children: A Clinician's Manual to Parent Training* (Barkley, 1987). The training programs have been led by two individuals, meeting weekly for seven weeks with fifteen families in each group. A followup booster session was conducted four weeks after the initial program ended. The manual provides detailed instructions for sequencing sessions and presenting techniques. Two research projects on the use of this strategy in parent training are under way at Iowa State University.

DESCRIPTION

At Iowa State University, the Barkley parent training model is conducted both alone and in combination with conjoint consultation. Barkley's model consists of increasing parents' knowledge regarding ADD, instructing parents on the benefits of positive play, use of language to increase compliance with children, and implementation of effective behavioral strategies with children. Conjoint behavioral consultation (CBC) is implemented with parents and teachers in some of the training. This plan includes the four stages of problem identification, problem analysis, treatment implementation, and treatment evaluation.

OUTCOMES

Use of the Barkley model has resulted in significant changes in parents' behavior, such as increased use of approving statements, and positive changes in child behavior, such as increased compliance. These changes were maintained over a significant time period. The training resulted in no changes in the children in the school setting. When CBC was apart of the training, the intervention resulted in increased home-school cooperation and enhanced quality of interventions and led to successful implementation of accommodation for children with ADD in the regular classroom.

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An ADD Training Program for Teachers
Lexington, Kentucky

BACKGROUND

In 1989, Barbara Burcham, Richard Milich, and colleagues at the University of Kentucky in collaboration with the Kentucky Department of Education entered into a project to develop a statewide teacher training program on ADD. The first step was to conduct an assessment of teachers' needs, which established that educators in this state lacked information on how to identify and intervene with students with ADD. Once the needs were identified, the content of the training was developed and a trainer-of-trainers model used to deliver the information.

DESCRIPTION

The program, "Attention Deficit Hyperactivity Disorder Diagnosis and Management: A Training Program for Teachers" includes an instruction manual and videotape. The videotape is divided into four sections, each running 10 to 40 minutes. The manual is similarly divided into four sections, with each section corresponding to one of the video sections. Material covered includes an overview of ADD, identification of ADD in the classroom, assessment strategies, medication and family interventions, classroom interventions, and resources. The proposed presentation involves viewing each video section and immediately having discussion and doing the exercises, as outlined in the manual. The program lasts approximately six hours.

OUTCOMES

Trainers in every county in Kentucky received this training and copies of the material so that they could return to their local schools and increase awareness regarding ADD. The product has been well received by school-based practitioners in this state and has been favorably reviewed by national experts.

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Prevention/Treatment Program for Kindergarten Students with ADD
Worcester, Massachusetts

BACKGROUND

In 1991, Russell Barkley and a colleague obtained a grant from the National Institute of Mental Health in collaboration with Worcester, Massachusetts, Public Schools to design and evaluate a kindergarten program for youngsters at risk for ADD or oppositional behaviors. The program was modeled on the ADD paraprofessional program of the University of California, Irvine. It essentially addresses three areas: the child's behavior, social development, and academic development. This program is implemented in a regular classroom with a teacher and an aide.

DESCRIPTION

The behavioral intervention component of the program includes monitoring of target goals for the child at 10-minute intervals. High rates of positive verbal feedback are used throughout the day. A response cost system and time-outs are used in the management of the students. The second component of the program is teaching the children social skills by using the Skills Streaming series. Social skills are practiced in class every day for 30 minutes. Academically, a developmental perspective is maintained: each student's program is designed to be at an appropriate instructional level.

Parents are involved in this program on a daily basis. They are notified by a daily report that tells them which skills are being taught and gives feedback on the child's performance for the day.

OUTCOMES

Preliminary analysis indicates that the intervention program is successful for kindergarten children.

For more information contact:
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(508) 856-3260

Development of an ADD Parent-Teacher Support Group
Lansing, Michigan

BACKGROUND

In fall 1986 a parent and a teacher formed the ADD Support Group of Grand Ledge, Michigan. This was the result of a parent wanting to find ways to educate herself about this disorder and a teacher recognizing that there is real opportunity in parents and teachers together discovering how best to serve these children at home and at school.

DESCRIPTION

The goals of the group are to become informed about ADD, to help schools educate these children, and to disseminate information about ADD to parents and teachers. The group is now affiliated with Children with Attention Deficit Disorder. It has monthly meetings that involve a time for a support group atmosphere as well as information sharing by experts, and formal committees work on various projects. The group now has more than 300 members and five satellite locations. An "Attention Deficit Hyperactivity Disorder Handbook" compiled by this group includes guidelines for teachers and parents in working with children with ADD.

OUTCOMES

The success of the ADD Support Group is evidenced by its continuing growth and the development of the five satellite groups. Many positive changes for children with ADD and their families have resulted from the existence of this group.

For more information contact:
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Early Screening for Children with ADD from Diverse Backgrounds
Minneapolis, Minnesota

BACKGROUND

Jason Walker, through his work at the Pilot City Mental Health Center in collaboration with the Minneapolis, Minnesota public schools developed an early identification process. It was designed to reduce the risk of misidentifying culturally diverse children with ADD — children suspected of having conduct disorders or academic performance deficiencies. The process includes an initial clinical interview with the parents, followed by parents' completion of a standardized behavior rating scale and by teacher interviews and classroom observations.

DESCRIPTION

During the first part of the clinical interview, parents state the problems and their history. Information is also obtained on developmental, school, and health history. This provides a picture of the child's attention span, impulse control, activity level, compliance with directions, and peer interactions. Parents receive information about the symptoms and criteria for ADD. Following the clinical interview the parent is asked to complete behavior rating scales. These include the Conners Parent Rating Scale, the SNAP Checklist, and the Achenbach Child Behavior Checklist. Next, the child's teacher is interviewed about the child's academic, behavioral, and social functioning in school. The child is then observed in the classroom to determine attention span, impulse control, and activity level.

All of this information combines to form a diagnostic impression of the child, which in turn assists the parents, teachers, and consulting psychiatrist in generating a treatment plan that is coordinated by the school, home, and clinic.

OUTCOMES

Several children of elementary age were being considered for special education by the school staff. However, after going through this identification process and the finalization of a treatment plan, they have been able to stay in the regular education program.

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Comprehensive and Intensive Treatment for ADD:
A Summer Treatment Program and Outpatient Followup
Pittsburgh, Pennsylvania

BACKGROUND

Since 1980, William E. Pelham has been running an intensive, summer day- treatment program for children with ADD. The program was started at Florida State University, and in 1987 Dr. Pelham moved the program to the University of Pittsburgh. Recently, several other universities, including Emory and Vanderbilt, have adapted the program for their use. This unique, state-of-the-art treatment program is conducted in a naturalistic setting to enhance generalization.

DESCRIPTION

The Summer Treatment Program (STP) is an intensive program for children with ADD. It runs for eight weeks in the summer, five days a week, from 8 a.m. to 5 p.m. The children are placed in groups of 12 and participate in academic and recreational activities each day. Throughout the day, a behavioral point system is in effect for each child, so that the children continuously receive points for appropriate behaviors and lose points for inappropriate behaviors. Five counselors are assigned to each group, and they are responsible for implementing the point system as well as running the recreational activities and other treatment interventions.

The STP provides treatment tailored to each child's individual behavioral and academic difficulties. Treatment may include a placebo-controlled medication assessment with varying dosages of medication. Other interventions include social skills training, individualized target behaviors, both computer-assisted and regular academic instruction, and group problem-solving discussions.

Parents are highly involved in the program. There are weekly parent training sessions to help them learn to implement effective behavioral management programs at home. In addition, daily report cards are sent home that describe the kind of day the children had in the program. In the parent training sessions, the parents are instructed in how to effectively reinforce their children when they reach their goals on the daily report cards.

At the end of the summer, the parents are offered the opportunity to continue treatment. This followup treatment can include a Saturday treatment program similar to the summer program, school interventions in the classrooms to which children return after the STP, and booster parent training.

OUTCOMES

Parents of the participants in the STP report overwhelmingly positive responses to the program. Almost without exception, they said they and their children showed dramatic improvement. In addition, parents said they would definitely send their child again if given the opportunity and that they would definitely recommend the STP to other parents. The dropout rate is extremely low (less than 3 percent, compared to rates as high as 50 percent in other treatment programs).

For more information about this program contact:
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Success Using Contingencies to Create Effective Social Skills
(SUCCESS)
Seattle, Washington

BACKGROUND

The SUCCESS program, developed by Hill Walker and colleagues consists of four separate programs that are designed to improve the social behaviors of children with behavior problems in kindergarten through third grade. The program focuses on four problems children experience: disruptive behavior, low academic survival skills, social aggression, and social withdrawal. The four SUCCESS programs are CLASS (Contingencies for Learning Academic and Social Skills), PASS (Program for Academic Survival Skills), RECESS (Reprogramming Environmental Contingencies for Effective Social Skills), and PEERS (Procedures for Establishing Effective Relationship Skills). This report describes CLASS, because children with ADD often need specific support in managing their disruptive behavior.

DESCRIPTION

CLASS provides a set of procedures, which are based on social learning principles, for modifying the classroom behavior of primary-grade children with disruptive behaviors. Children who act out are defined here as those children who defy classroom rules, structures, and procedures and who display high rates of such behaviors as noncompliance to teacher instructions and directions, inappropriate peer interactions, verbal or physical aggression, and destruction of property. Because children who act out spend considerable time engaged in nonacademic pursuits, they are often below grade level in essential academic skills. The main objective of the CLASS program is to increase the child's levels of academic achievement and to decrease the frequency of maladaptive, interfering behaviors.

CLASS is a set of procedures instituted by a consultant who employs rewards to shape such appropriate classroom behaviors in children. Points earned at school are exchanged for group activity rewards and backed up with a home reward system. The consultant turns control of the program over to the teacher, who gradually fades out the point system and maintains appropriate behavior by contingent social praise.

OUTCOMES

Field testing of the CLASS program showed that consultants could be effectively trained to use its procedures and that acting-out students in the CLASS program made significantly greater gains in appropriate classroom behavior than did matched control students. Also, field tests showed that the children participating in CLASS needed significantly less special education service over a three year period than control students did.

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MATERIALS

Materials

Materials are an essential part of the curriculum when plans are developed for educating children with ADD. They are tools that allow creative educators to enhance the learning experience for children. Materials include classroom intervention resources, technical assistance manuals, academic programs and books, social skills programs, parent training programs, assessment instruments, and a host of other items such as books and videos. To develop effective educational programs one must be cognizant of the types of materials available, how they are integrated into the curriculum, and how they can be used and modified for students with ADD.

Although no specific classroom teaching curriculum that shows strong promise in serving students with ADD was not submitted to the FRC for review or discovered during the site visit portion of this project, no one should infer that material is unavailable. Barkley (1990) suggests that several issues be considered in reviewing material for use with students with ADD in the classroom: (1) Materials should be well matched to students' abilities and needs; (2) The format and presentation of material should be varied; (3) When using material with children, one should remain sensitive to the child's inattention and need for frequent feedback; and (4) Materials should be used in an enthusiastic yet task-focused fashion.

As a result of the FRC's efforts, this project did locate a wide range of material that may be useful in serving students with ADD. This material fell into three broad groups: commercially prepared material, locally prepared materials, and samples of intervention aids developed by school-based practitioners to support their work with students with ADD.

Commercially Prepared Materials
Longmont, Colorado

Project RIDE

Obviously there are numerous commercially prepared materials available that may be useful with students with ADD. However, only one was submitted for review, namely, *Project RIDE* (Responding to Individual Differences in Education), authored by Ray Beck, Ed.D. This material shows strong promise for serving students with ADD, even though the product was not developed for this specific group of youngsters.

As described by Dr. Beck, *Project RIDE* is a model program designed to help teachers accommodate individual student differences. It is a support system that operates on the premise that teachers, when provided with the necessary resources and support, can become their own best problem solvers. The overall goal of *Project RIDE* is to accommodate the needs of at-risk learners, from kindergarten through grade 12, in a manner that is as close to the regular classroom as possible. This project adheres to the theme that every student, whether typical or at risk, belongs to the educational family and should be considered the responsibility of the entire building staff.

There are three main components to *Project RIDE*. The first focuses on effective classroom practices. A set of questions is provided to prompt the teacher to define, refine, and modify existing management practices. The second is a computerized tactics bank and video library. The bank contains more than 360 empirically validated practices written in language familiar to teachers. The video library is an extension of the bank and contains scenarios for carrying out selected strategies. The last component focuses on how to implement schoolwide assistance teams to serve students at risk.

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Longmont, CO 80501
(303) 651-3230

Locally Prepared Materials

School-Physician Collaboration for the Student with Attentional Difficulties: Handbook for Intervention
San Diego, California

This handbook, developed by the Project for Attention-Related Disorders (PARD), features a set of forms developed to facilitate collaboration between school and private medical and mental health personnel for the well-being of children with ADD. Included are school-based screening and database questionnaire, information and questions to assist in identifying appropriate helping professionals; and summary and intervention forms, including a classroom strategies handout and monitoring forms for use in drug trials and medication flow.

The contents of this handbook are in seven parts: introduction, screening, data collection, seeking professional assistance for the child with ADD, physician tools, strategies for classroom teachers, and references.

This material is used in the promising practice described on page 75.

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Hard To Reach and Teach — ADD/ADHD Children
San Diego, CA

This guide is designed as a comprehensive handbook for teachers and site teams in meeting the special needs of our most challenging students. Strategies suggested throughout are appropriate and recommended for all students who appear to have possible attention deficits or learning disabilities, or who are underachieving for any number of reasons.

Strategies and techniques discussed in this manual are also instructional focuses of the district, including learning styles, cooperative learning, multisensory instruction, study skills and organizational skill training, "whole language" strategies, math strategies that are predominantly hands-on, and cooperation and problem solving in nature and language arts.

This material is used in the promising practice described on page 75.

For more information contact:
National Professional Resources, Inc.
25 South Regent Street, Suite 493
Port Chester, NY 10573
(800) 453-7461

Broward County Screening Procedures
Fort Lauderdale, Florida

Broward County (Florida) Public Schools has developed materials to outline its process in responding to the needs of children with ADD who may be eligible for services under Section 504 of the Rehabilitation Act of 1973. The products include two documents, "Broward County Schools Guidelines for Section 504 of the Rehabilitation Act of 1973" and "Broward County Schools Screening Procedures Section 504 of the Rehabilitation Act of 1973." The system has also developed a videotape to describe Section 504 implementation specific to students with ADD. The basic components include legal considerations; pertinent information about students with ADD; the process by which interventions are developed to assist the student in the classroom; information on how to evaluate children with ADD and monitor their progress; and options when the student has not progressed despite multiple intervention efforts.

Broward County Schools also developed a brochure, "ADD: My Child Can't Pay Attention" and an attention deficit disorders handbook that describes the nature of ADD; issues regarding assessment, medication, and educational interventions; and a model for developing a child study team. Parenting issues are also described.

For more information contact:
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Developing Home School Intervention Plans to Manage the Behavior of Children with Attention Problems
Reno, Nevada

This is a syllabus developed for a staff development course by the school psychology staff that is designed to provide participants with a broad understanding of the importance of how a child's ability to focus attention contributes to the learning process. It includes a discussion of the current neuropsychological theories concerning attention deficits and strategies to manage the behavior and increase the learning of children with ADD. Aimed at teachers, counselors, psychologists, and nurses, the course consists of four meetings of 4-hours each. The syllabus includes background information, family issues and parental involvement, classroom interventions, medical interventions, and community resources. There also is a resource manual, "Educational Ideas to Help Children with ADD."

A basic assumption of the course is that for years teachers have been very good at developing interventions for children exhibiting inattentive, impulsive, or noncompliant behavior. Examples of these interventions are included in the resource manual.

This material is used in the promising practice described on page 110.

For more information contact:
Washoe County School District
425 East Ninth St.
Reno, NV 89520
(702) 348-0331

ADD Screening Procedures Manual
Raleigh, North Carolina

This ADD screening procedures manual is for school assistance teams by the school psychology staff. It is designed to encourage a consistent and appropriate procedure among the district's schools in dealing with all children who are suspected of having ADD. The manual contains the following information:

1. General information on ADD
2. Recommended procedure for screening
3. Interventions and strategies that can be used with children who have attention and concentration difficulties or high physical activity levels
4. Recommended behavior rating scales and information on how to obtain scales and interpretive manuals
5. Interpretation forms to assist in reporting rating scale results
6. Summary checklist

This material is used in the promising practice described on page 66.

For more information contact:
Carol Rahmani
Wake County Public School System
Psychological Services
3600 Wake Forest Rd.
P.O. Box 28041
Raleigh, NC 27611
(No phone number provided at the request of the school district.)

Attention Deficit Disorder: A Handbook
Middlebranch, Ohio

This handbook is designed by parents with some facts, thoughts, and ideas to help other parents who are new to this situation find some answers and understanding of ADD, which can be bewildering. It is also offered as a resource for professionals and laypeople who would like to have a better awareness of the ADD child who will touch their lives, be it in the classroom, on the playing field, or in their back yard.

The contents of the handbook are three parts, each consisting of an overview, description, questions and answers, and tips:

1. Attention Deficit Disorder: Awareness and Diagnosis
2. Education, Parental Concerns, and a Teacher's Perspective
3. Home and Social Environment

This material is used in the promising practice described on page 117.

For more information contact:
ADD Partnership of Ohio
P.O. Box 224
Middlebranch, Ohio 44652
(216) 497-9772

Intervention Aides

Most of the promising practice sites described in this report developed materials that school personnel could use to facilitate service delivery to students with ADD. These include medication monitoring forms, a daily report card, assignment sheets, consultation records, peer comparison behavior observation forms, and so on. Examples of these intervention aids are provided in Appendix E. The name of the school district and the contact person, and the phone number are listed at the bottom of each page. Please contact the district if you desire more information regarding use of the aid.

The intervention aids included represent only a sample of the material used in districts. This list is not intended to be an inclusive summary of all the supports developed and used by the promising practice sites identified by the FRC.

IMPLICATIONS

Implications

As the Federal Resource Center for Special Education staff and consultants reviewed promising practices for children with ADD and completed site visits of schools engaged in this work, several factors emerged that seemed to influence the educational outcomes for the students. These include: characteristics of the children, characteristics of the personnel working with the children, relationships that children with ADD have with their peers, the school's administrative structure, and family and community issues.

Lloyd, Kauffman and Kupersmidt (1990) have studied these characteristics and suggest that they must be given careful attention when designing effective programs for children with behavior problems. For example, effectively serving children with ADD may depend on a range of child factors, including: knowledge of the severity of the attention deficit, the presence of co-occurring disorders, whether or not the child is on medication, the child's learning ability, family issues, or a myriad of other factors related to the child. Schools engaged in promising work were attentive to individual child characteristics when designing specifics of educational plans for students with ADD.

Although attention to child factors is important in serving children, characteristics of the school-based professionals involved with the students also appeared essential. Teacher attitude toward students who display behavioral challenges has been most widely researched by Walker and his colleagues (Walker, 1983, 1986; Walker and Lamon, 1987; Walker and Rankin, 1983, 1989). They note that teachers vary widely in their willingness to work with students. As Lloyd, et. al. (1990) points out, interventions for students with behavioral problems should be aimed at teaching new skills to the professional working with the student as well as to the child. Greene (1993) urges educators to begin conceptualizing the characteristics of students and their teachers as factors within a "compatibility equation". He suggests that school-based professionals ask not only what the child's response to a particular teacher and intervention is, but also what the teacher's response to the child and the intervention is.

The personnel interviewed and observed by the FRC staff demonstrated a commitment to working with students, understood the complexity of ADD, and believed strongly in the services they were providing. The teachers, administrators, psychologists, nurses, counselors, and paraprofessionals wanted to be involved with this group of children and exhibited a positive and enthusiastic attitude. Clearly, as the FRC staff observed successful practices, the issues of teacher attitude and "fit" between school personnel and children frequently emerged as components of the promising work with children with ADD.

Children with ADD often experience social rejection from their peer group. During the FRC site visits, it was noted that these children are viewed as unpopular and behave in socially inappropriate ways on the playground and in unstructured classroom activities when specific interventions are not provided. Difficulties in peer relationships among children with ADD are well documented in the literature (Milich and Landau, 1982; Pelham and Milich, 1984). Schools doing promising work with children with ADD were assessing the social competence of students and involving them in a variety of social skills training programs. In addition, some schools were exploring methods of strategically involving regular peers in social experiences with children with ADD.

Schools working successfully with students with ADD were also observed to provide strong administrative support for practices to support these children and their families. Strong administrative support had a number of positive effects, including wise use of human and fiscal resources. Administrators interviewed by the FRC staff at promising practice sites clearly recognized ADD as a disability. They were willing to develop policies supportive of this group of children and their families and commit resources to providing appropriate educational opportunities for them.

Lastly, schools engaging in promising work with students with ADD often had a genuine commitment to working with the child's family. When families are viewed as partners and experts about their children, better outcomes are achieved for students (Klein, 1993). Schools working with children with ADD found creative ways to engage families in the education of their children. Examples of activities include: inviting parents to participate as trainers in staff development activities, providing child care during conferences, having social activities such as meals in conjunction with parent training, and cooperatively developing newsletters targeting issues of concern for educators and parents. These schools maintained a supportive attitude of serving children and families, based on the strengths and needs identified by the family as well as the school.

No single educational plan for students with ADD can comprehensively meet the needs of every youngster. This is understandable, because students vary in their needs and schools have access to different resources. Attention to the themes described above may assist school personnel who are developing or adopting practices to serve students with ADD and their families. The following questions may be used as a guide to determine whether a practice does indeed hold promise for serving students with ADD:

- Will *the practice have a positive impact on the student with ADD and the family*? Before implementing a practice, one should consider whether a change in educational design could result in a positive effect for the student. Associated issues to consider may be how to assess whether change has actually occurred, how to maintain the change, how to generalize the change, and who considers the change desirable.

- *Does the practice have practical application*? This question goes beyond whether a positive outcome was observed. It also touches on whether the practice has value either at home or at school. Examples could be cited of experimental interventions that may effect positive change under certain controlled circumstances in a laboratory. However, the realities of school or home may bring into question the usefulness of such treatment. The issue of practicality is critical when developing practices that work in a school setting.

- *Does the practice target at least one of the major characteristics associated with ADD (inattention, impulsivity, and overactivity) and make a unique application of an activity to one of these characteristics*? These characteristics influence children's academic performance as well as their behavior. Sound practices designed to serve students with ADD will not only focus on these issues but go a step beyond to ensure that the practice is responsive to the individual needs of the child and family. Ideally, these issues should be addressed early in a child's educational career.

- *Does the practice focus on strengths as well as needs*? Many practices concentrate on the child's, the parent's, the school's, or the community's weaknesses without appropriate consideration of strengths. Practices that show promise address the needs but build on the strengths of the individuals or groups involved to accomplish positive results.

- *Does the practice show evidence of interdisciplinary collaborative involvement*? The old saying that two (or three or four) heads are better than one is applicable to resolving the puzzle of serving students with ADD and their families. The work of identifying and intervening with students with ADD should be a team accomplishment. This should be evident in districtwide policy decisions as well as in individualized educational planning for students. To achieve positive educational outcomes for these students, school personnel, families, and community service providers must work together.

- *Does the practice encourage family involvement*? Better outcomes for students with ADD can be anticipated from practices that proactively plan for legitimate, continuous, and positive parental involvement in the identification and intervention processes. Parents are experts on their children, and they should be actively involved as participants in planning their children's education.

- *Is the practice sensitive to issues of multicultural diversity*? Evaluations and interventions used with students with ADD from diverse cultures should address potential bias in assessment procedures, tease out language issues that may be contributing to inattention, and show sensitivity for the child's background when interventions are developed.

- *Are issues relevant to medical intervention adequately addressed*? Given that pharmacological intervention is the most common form of medical treatment for children with ADD, schools play a critical role in monitoring it. Often physicians need behavioral data to assist in determining the need for the medication, as well as school-based data to adjust the dose. Schools are often in the best situation to report the side effects of medications as well. Thus, promising practices that claim to address the issue of medication will focus on the aforementioned characteristics.

- *Does the practice have administrative support*? It is essential to have the full support and understanding of the district's administration in developing and implementing practices for students with ADD. Districts that were effective in serving these children secured support of the superintendent, school board, and building principals so that resources could be made available. This range of support may include allowing time off for training, allocating adequate space, purchasing appropriate materials, and hiring specialists knowledgeable about ADD.
- Is *there a plan to provide training to the staff*? Districts that were effectively serving students with ADD developed a systematic and comprehensive training program specific to ADD. These districts recognized that ADD is a discernible disorder, and they trained school staff on the nature of ADD, how to identify it at school, and appropriate school-based intervention strategies.

It is important to note the areas in which the FRC was able to locate only minimal information regarding promising school-based practices for serving students with ADD. First, evaluation and interventions used with students from diverse cultures should address potential bias. However, bias was described in a very limited manner in the practices reviewed by this project. Secondly, most of the promising practices focused on elementary and middle school students and gave little attention to preschool or secondary school students. Thirdly, there was limited focus on academic curricula that may be particularly suitable for students with ADD.

However, it was exciting to learn about the collaborative efforts among school personnel, parents and communities to effectively serve children with ADD. Effective service requires knowledge about the disability, a solid grounding in applied behavioral analysis, skill in instructional design, as well as an understanding of relevant medical issues. It also requires careful relationship development with students and their parents. The complex task of serving this population of students requires more than designing and implementing promising identification or intervention programs. Effective service for these children also requires an evaluation and understanding of the system in which these children and their families live and learn.

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APPENDIX A

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APPENDIX B

WANTED!

PROMISING PRACTICES
for serving children with
ATTENTION DEFICIT DISORDERS

The U. S. Department of Education is searching for effective **school-based practices in assessment and intervention** in serving children and youth with Attention Deficit Disorders (ADD). It is recognized that school personnel are often doing excellent work with this group of children and their families. However, teachers and other school personnel report that they want and need more information on how to successfully educate these children.

This is an opportunity for you to share the strategies that make a difference with children who have ADD and/or their families. ***Tell us what works!***

If you have a practice that shows promise in working with children with ADD and/or their families, OR if you know someone who does, please complete the form below and return it **no later than December 1, 1991**. For your convenience, simply fold, tape shut, and mail this form as **the postage is pre-paid**. Upon receipt, further information will be sent on how to submit the actual practice for review.

PRACTITIONER'S INFORMATION FORM:

Name: ______________________________ Title: ______________________________

School: ______________________________ Principal: ______________________________

School Address: ______________________________
____
______________________________ ZIP CODE ______________

School Telephone: (______) ______________________

University of Kentucky
The Federal Resource Center
Attn: Bobbie Burcham
314 Mineral Industries Building
Lexington, KY 40506-0051

The FEDERAL RESOURCE CENTER working in cooperation with the U.S. DEPARTMENT OF EDUCATION.

APPENDIX C

INSTRUCTIONS
FOR NOMINATING A PRACTICE

DIRECTIONS

- Complete the COVER SHEET in full and attach it as the first page of your application. Be sure to check the type of nomination (assessment or intervention) you are making. (Note: The code in the upper right hand corner of the cover sheet will be assigned by the Federal Resource Center staff and will be used to facilitate a blind review of all practices submitted.)

- If you are submitting an assessment practice, then refer to the enclosed **blue** sheet for specific instructions. If you are submitting an intervention practice, then refer to the **green** sheet for specific instructions.

- Complete your nomination in narrative form using the outline provided.

- Please **type** your submission. You should **double space** and the final product should not exceed ten pages.

- If you have prepared materials that describe your practice, please include them in addition to your nomination proposal.

- Mail your application in the enclosed **postage paid** envelope to: The Federal Resource Center, University of Kentucky, Attn: Bobbie Burcham, 314 Mineral Industries Building, Lexington, KY 40506-0051. The deadline in **February 1, 1992.**

TIPS

- We are interested in a clear **description** of your practice, the **outcomes** associated with it and what would be needed to **replicate** your practice. Therefore, focus on these three elements and use language that communicates clearly.

- The criteria that the reviewers will use to select practices that show promise are included in the narrative outline guide. Using these as you prepare your nomination for submission will increase the chances that your practice will be selected.

- Remember, it is a practice that we want, not a program. You may be working with children diagnosed as ADD in regular, special or alternative programs. We are interested in the practices that make those programs work. The same principle applies to programs in which administrators, counselors, nurses or other school personnel are involved. What specific practices within the program make it work for children with ADD and/or their families? The practice may be innovative, creative or a standard tried and true way of working with children and families. For example, you may have developed a strategy to get families involved in the assessment process or a method to increase communication among the medical community, schools and families or you may be using a creative method of teaching children how to be better listeners. These are practices, not comprehensive programs. Tell us about the practices that you know work!

(For office use only) Code:

COVER SHEET

Basic Information

Name: ______________________________ Title: ____________________________________

School: ______________________________ Principal: ________________________________

School Address: ____

____

_______________________ ____________________ Zip ____________

School Telephone: (________) _________________________

Home Telephone: (________) _________________________

Type of Nomination

Please **check** the primary area in which you are nominating the practice. You may nominate as many practices as you wish in either category, however a separate cover sheet and application must be completed for each one submitted.

☐ ASSESSMENT

Practices in this area may include educationally relevant methods of assessing the child with ADD and/or the family, how families are involved in the assessment process, practices that address how school personnel are involved in issues of medication assessment, and the kind of training that is useful in preparing school personnel to appropriately assess children with ADD and/or their families.

☐ INTERVENTION

Practices in this area may include the kind of material, technology, or instructional strategies school personnel have found useful in working with children with ADD and/or their families. The practices may also include such topics of the ways schools involve families in the planning and implementation of interventions for children and the kind of training school personnel need to effectively intervene with students with ADD and/or their families.

BEST COPY AVAILABLE

This cover sheet must be included for the nomination to be reviewed.

INTERVENTION NOMINATION
NARRATIVE OUTLINE

The outline below is provided as a guide for your writing. Please follow the format as we need a clear description of your practice, the outcomes associated with it and what would be needed for replication.

I. DESCRIBE THE PRACTICE

Provide a clear description of your practice including sufficient detail so that others would be able to understand what you do. You may want to describe the following as applicable: the **need** that is being addressed by implementing the practice; the **goals and objectives** of the practice; the **"how to"** of implementing the practice; the individual or group with whom you are using the practice; the **staffing** needed to implement the practice as well as the skills and **training** needed by the staff; the way in which families, students, the community, etc. are involved in the practice; the **materials** needed; the kind of organizational/administrative **support** that is being provided; and any unique or distinguishing features of the practice.

II. OUTCOMES

Please describe what happened when you implemented the practice. Note the change that occurred as a result of using the practice . You may wish to describe specifically who or what changed as a result of the practice, as well as how you knew that change occurred and how long the changes lasted. In addition, please note any unplanned benefits associated with the practice.

III. REPLICATION

Please provide the detail needed so that other professionals at other sites could adopt your practice with the expectation of similiar results. As you write, you may wish to discuss the setting in which the practice is being used; other settings where you think the practice could be used with minor modifications - for example your behavior management system worked well in a primary setting but you project it could be very useful in a middle school setting if age- appropriate reinforcers were introduced; the human and physical resouces (i.e. staff, training, materials, facilities, administrative support, etc.) needed to initiate the practice; and the start-up and maintenance costs that are associated with implementing the practice.

*THE FOLLOWING CRITERIA WILL BE USED BY REVIEWERS TO SELECT PRACTICES IN INTERVENTION:

- •The intervention has a postive impact for the child with ADD and/or the family.
- •The intervention has practical meaning or educational relevancy in the school setting.
- •The intervention can be replicated at other sites with the expectation of similiar results.
- •The intervention enhances learning for the target population whether it be teachers, children, families, or others.
- •The intervention is designed to consider acquisition of desired behavior and/or academic material as well as maintenance and generalization.
- •The intervention development and/or implementation considers collaborative involvement including families and/or the community.
- •The strenghts and needs of the target population are considered in the intervention.

If your practice relates to medication issues, the the following criteria may also be applied:

- •The intervention incoporates the collaborative input of the school, family, and medical community.
- •The intervention is sensitive to the behavior and/or academic performance of the child prior to medication.
- •The intervention is sensitive to the effects of medication on the child's academic performance and/or behavior.
- •The intervention is sensitive to the side effects of medication.

*Please note that many practices, depending on the nomination, may not address all the criteria.

ASSESSMENT NOMINATION
NARRATIVE OUTLINE

The outline below is provided as a guide for your writing. Please follow the format as we need a clear description of your practice, the outcomes associated with it and what would be needed for replication.

I. DESCRIBE THE PRACTICE

Provide a clear description of your practice including sufficient detail so that others would be able to understand what you do. You may want to describe the following as applicable: the **need** that is being addressed by implementing the practice; the **goals and objectives** of the practice; the **"how to"** of implementing the practice; the individual or group with whom you are using the practice; the **staffing** needed to implement the practice as well as the skills and **training** needed by the staff; the way in which families, students, the community, etc. are involved in the practice; the **materials** needed; the kind of organizational/administrative **support** that is being provided; and any unique or distinguishing features of the practice.

II. OUTCOMES

Please describe what happened when you implemented the practice. Note the change that occurred as a result of using the practice . You may wish to describe specifically who or what changed as a result of the practice, as well as how you knew that change occurred and how long the changes lasted. In addition, please note any unplanned benefits associated with the practice.

III. REPLICATION

Please provide the detail needed so that other professionals at other sites could adopt your practice with the expectation of similiar results. As you write, you may wish to discuss the setting in which the practice is being used; other settings where you think the practice could be used with minor modifications - for example your behavior management system worked well in a primary setting but you project it could be very useful in a middle school setting if age- appropriate reinforcers were introduced; the human and physical resouces (i.e. staff, training, materials, facilities, administrative support, etc.) needed to initiate the practice; and the start-up and maintenance costs that are associated with implementing the practice.

*THE FOLLOWING CRITERIA WILL BE USED BY REVIEWERS TO SELECT PRACTICES IN ASSESSMENT:

- The assessment practice has a positive impact for the child with ADD and/or the family.
- The assessment practice has practical value or meaning in educationally classifying or intervening with the child with ADD and/or the family.
- The assessment practice can be replicated at other sites with the expectation of similiar results.
- The assessment practice acknowledges the benefits of early detection.
- The assessment practice covers the three major components of the disorder including inattention, impulsivity and overactivity.
- The assessment practice focuses on strenghts as well as needs.
- There is evidence of collaborative involvement in the assessment practice including families and/or the community.
- There is evidence of sensitivity to issues relevant to multicultural diversity in the assessment practice.

If your practice relates to medication issues, the the following criteria may also be applied:

- The practice incoporates the collaborative input of the school, family, and medical community.
- The practice includes a method of assessing the behavior and academic performance of the child prior to medication.
- The practice includes a method of assessing the effects of medication on the child's academic performance and behavior.
- The practice includes a method to assess the side effects of medication.

*Please note that many practices, depending on the nomination, may not address all the criteria.

APPENDIX D

ADD PRACTICE DESCRIPTIONS
SCORING GUIDELINES

MISSION:

The FRC's mission is to identify school-based practices in ADD that show promise in working with children and youth with ADD and their families. We are currently collecting information about practices from school-based practitioners across the country. Practices submitted to the FRC for review will be scored by the stakeholder consultants. This information will then be used to make selections of practices to be included in the draft document of promising practices in the area of ADD for the U.S. Department of Education.

THE FRC'S ROLE:

The FRC met with the core group of stakeholder consultants in October. Plans were made regarding how to capture the craft knowledge of school-based practitioners in their work with children with ADD. This work included development of criteria to serve as a guide in the process of identifying promising practices in the assessment and intervention of children and youth with ADD and their families. The process to identify individuals doing promising work with these children resulted in obtaining 504 names. Each of these individuals was sent a packet of material asking them to describe their work. Submission deadline is February 1st. The staff at the FRC will: process and duplicate the applications, assign a review code number, designate the practice to three independent reviewers, and mail out to the reviewers along with appropriate scoring materials.

YOUR ROLE:

GENERAL BACKGROUND

All of the stakeholder consultants are being ask to participate in the review of the practice descriptions. These group is composed of school personnel (e.g. teachers, administrators, school psychologists, etc.), parents, researchers, family treatment professionals and health professionals. They will review the descriptions of the submitted practicesr to provide an impartial assessment. Each practice will be reviewed by three independent consultants. One member will be a representative of the educational community. The FRC will assign the stakeholder consultants to review specific applications. The consultants will not score applications from programs with which they are associated either as a project director, as a consultant, or one from their geographical region. Stakeholder consultants will be mailed the practices they are to reivew the week of February 17th and they should be returned to the FRC the week of March 9th.

TRAINING ON SCORING

All consultants reviewing practice descriptions will be trained via teleconference the week of February 10-14, prior to receiving any actual practice nominations. The specific times have been scheduled with each consultant. The purpose of this training will be to provide a consistent framework for rating the descriptions and implementation of the scoring procedures. A sample practice description will be used in the training. Each consultant should review all scoring material prior to the teleconference and score the sample practice description. This will be reviewed in the training session.

WHAT YOU DO

It will be the reviewers' responsibility to independently read and critique the application, note strengths and weaknessses and provide a score based upon the established criteria and guidelines. When individuals were sent instructions for nominating a practice, they were ask to include the following information: Description - describe the need, note goals and objectives, state how to implement, relate staffing and training needs, and report materials and support needed to implement the practice; Outcomes - describe the impact, note who or what changed, and report evidence for the change; and Replication - indicate in what setting the practice is used, note other possible settings and needed modifications and indicate needed resources and costs. The strengths and weaknesses should be noted on the Review Form for each area. Comments should be specific and referenced to the practice. The description and outcome sections of the application will be worth a maximum of 40 points each while the replication section will be worth a maximum of 20 points. The reviewer should indicate the assigned points for each section as well as the total points on the Summary Review Form. In addition, the reviewer should complete all remaining sections on the Summary Review Form, including the summary analysis, comments,the signature and the date.

HOW TO REVIEW AND SCORE THE APPLICATION

- Critically read the application, listing as many strengths and weakneeses as possible on the Review Forms 1, 2 & 3 for the Description, Outcome and Replication portions of the application.
- Evaluate important information. Is it logical? Does it address the criteria as applicable? Refer to the criteria sheet for either assessment or intervention (AorB) as a reference.
- Does the application address the three areas of description, outcomes and replications ? Refer to guidelines referenced on the Review Forms 1,2&3.
- Assign the Description section points ranging from zero to forty.
- Assign the Outcome section points ranging from zero to forty.
- Assign the Replication section points ranging from zero to twenty.
- Complete the Summary Review Form 4.
- Indicate on the Summary Review Form 4, to what degree the practice shows promise.
- Mail the Review Forms 1,2 &3 and the Review Summary Form 4 to the FRC by the week of March 9th.

NEXT STEPS:

Upon completion of the scoring, the stakeholder consultants will return the scored practices to the FRC by the week of March 9th. Each practice will have three independent scores. The scores from the three raters will be correlated together to determine interrater reliability. If the reliability is sufficient, the three scores will be averaged to produce a final score. If only two of the scores correlate sufficiently together, these two scores will be averaged together, and the third score will be discarded. If no pair of ratings shows sufficient interrater reliability, a fourth rating will be collected.

Based upon the stakeholder consultant's review, the selection of practices to be included in the report to the U.S. Department of Education will be made at the April meeting of the core stakeholder consultants. These selected practices will be included in a draft document of promising school-based practices which will be submitted to OSEP in May for critique and approval.

Form 1

Review Form Code ______

List the significant strengths and weaknesses of the attached practice. Refer to the Assessment or Intervention Criteria sheet for guidance in the review process.

DESCRIBE THE PRACTICE

Topics that were to be addressed in the application

- Describe the need
- Note goals and objectives
- State how to implement
- Relate staffing and training needs
- Report materials/support needed

Strengths:	Weaknesses:

Maximum 40 points. Awarded points ____

Form 2

Review Form

Code ______

List the significant strengths and weaknesses of the attached practice. Refer to the Assessment or Intervention Criteria sheet for guidance in the review process

Topics that were to be addressed in the application

OUTCOMES

- Describe the impact
- Note who/what changed
- Report evidence for the change

Strengths:	Weaknesses:

Maximum 40 points. Awarded points ____

Form 3

Review Form

Code ______

List the significant strengths and weaknesses of the attached practice. Refer to the Assessment or Intervention Criteria sheet for guidance in the review process

Topics that were to be addressed in the application

REPLICATION

- Indicate in what setting the practice is used
- Note other possible settings and needed modification
- Indicate needed resources/costs

Strengths:	Weaknesses:

Maximum 20 points. Awarded points ____

Form 4

Summary Review Form
School Based ADD Practices

Application Code Number: ________

ADD Practice Area:

☐ Assessment ☐ Intervention

Areas	Maximum Points	Assigned Points
Description	40	
Outcomes	40	
Replication	20	
Total Score	100	

Summary:

☐ Shows strong promise; Worth sharing.
☐ Shows some promise; Consider sharing.
☐ Does not show promise; Do not disseminate.

Comments:

Reviewer's Signature: ______________________ Date: ________

A

ASSESSMENT CRITERIA SHEET

KEYWORDS	ASSESSMENT
Impact	*The assessment practice has a positive impact for the child with ADD and/or the family.* Does the practice result in a change for the better for this child and/or the family? For example, is a "standard battary" approach used regardless of the assesment question or does the practice allow for flexibility depending on the nature of the referral issues?
Value	*The assessment practice has practical value or meaning in educationally classifying or intervening with the child with ADD and/or the family.* Does the practice link assessment to intervention? Does it lead to better services for the child and family?
Replication	*The assessment practice can be replicated at other sites with the expectation of similiar results.* This should be specifically addressed in the replication section. Are there issues related to the practice that make it difficult to reproduce in another setting such as extraordinary costs, staffing needs, training, etc.? If there are such issues, how could they be resolved?
Early Detection	*The assessment practice acknowledges the benefits of early detection.* For example, does the assessment practice address the benefits of training staff to evaluate characteristics of ADD in young children so early treatment may be established?
Three Components	*The assessment practice covers the three major components of the disorder including inattention, impulsivity and overactivity.* Are the three major components of the disorder addressed in the assessment practice?
Strengths/ Needs	*The assessment practice focuses on strengths as well as needs.* Does the assessment practice solely address weakneeses in the child or does it consider both the strengths and needs of the student?
Collaborative	*There is evidence of collaborative involvement in the assessment practice including families and/or the community.* Does the assessment strategy involve key individuals outside the school setting as well as those in school individuals working with the child?
Diversity	*There is evidence of sensitivity to issues relevant to multicultural diversity in the assessment practice.* Does the practice include methods to prevent overidentification or underidentification of children in minority groups?

ASSESSMENT/MEDICATION

Collaborative	*The practice incorporates the collaborative input of the school, family and medical community.* When children are being considered for medication, does the school make an effort to integrate information helpful in that process?
Prior to Medication	*The practice includes a method of assessing the behavior and academic performance needs of the child prior to medication.* Does the practice include a strategy for evaluating and reporting needs of the child both behaviorally and academically?
Post Medication	*The practice includes a method of assessing the effects of medication on the child's academic performance and behavior.* After the child is placed on medication, does the practice include a method of monitoring the effect on school performance and behavior?
Side Effects	*The practice includes a method to assess the side effects of medication.* After the child is placed on medication, does the practice include a method of monitoring the side effects of the medication.

BEST COPY AVAILABLE

B

INTERVENTION CRITERIA SHEET

KEYWORDS	INTERVENTION
Impact	*The intervention has a positive impact for the child with ADD and/or the family.* Does this intervention result in positive change for this child and/or the family?
Value	*The intervention has practical meaning or educational relevance in the school setting.* Some interventions may result in change, but they are not seen as practical or meaningful in the school setting. The point here is to evaluate if the practice has educational relevance.
Replication	*The intervention can be replicated at other sites with the expectation of similiar results.* The nominee should specifically address this in the replication section of the application. Is the practice one that other school-based practitioners could imitate without extrordinary costs, training, etc.? If there are specific costs, training, and so on required, how can that need be addressed?
Learning	*The intervention enchances learning for the target population whether it be teachers, children, families, or others.* Does the practice enhance learning and growth for the population for which it was designed?
Maintenance/ Generalization	*The intervention is designed to consider acquisition of desired behavior and/or academic material as well as maintenance and generalization.* Does the intervention practice stop with the acquisition stage or learning or does it explain how maintenance and generalization were attained?
Collaborative	*The intervention development and/or implementation considers collaborative involvement including families and/or the community.* Is the intervention developed or implemented in isolation or in conjunction with the family and others as appropriate?
Strengths/ Needs	*The strengths and needs of the target population are considered in the intervention.* Is the intervention centered solely around the child and/or family needs or does it consider strengths as well?

	INTERVENTION/MEDICATION
Collaborative	*The intervention incorporates the collaborative input of the school, family and medical community.* When medication is used as an intervention for children, does the school make an effort to integrate and share information helpful in monitoring?
Prior to Medication	*The intervention is sensitive to the behavior and/or academic performance needs of the child prior to medication.* When a family and/or physician is considering placing a child on medication, does the practice include a method of evaluating and communicating the need in the school setting prior to making the decision?
Post Medication	*The intervention is sensitive to the effects of medication on the child's academic performance and/or behavior.* After the child is on medication, does the practice include a method of monitoring the effect on behavior and academic performance?
Side Effects	*The intervention is sensitive to the side effects of medication.* After the child is placed on medication, does the practice include a method of monitoring the side effects of the medication?

SAMPLE PRACTICE DESCRIPTION
for Teleconference Training Session

DESCRIBE THE PRACTICE:

NOTES:

The practice described in this application is a teaching strategy used to increase children's ability to follow directions. The strategies are based on the work of Forehand and McMahan (1981). The philosophy behind the implementation of this approach with my first grade class that all students, particularly those with ADD, needed to follow instructions better.

- Need

The need for a change in the current system was documented by the four teachers in the first grade program at our elementary school gathering data on the rate of compliance with instructions among our first graders. There are six children in the four classes diagnosed as ADD and separate data were gathered on those children. The school psychologists assigned to our building collected the data, coming to our classes for two thirty- minute periods per day for one week. Among those children not diagnosed as ADD, the percent of compliance with instructions was 52%, whereas among the six children diagnosed as ADD the compliance rate was 31%. Clearly all the children could improve on the following of instructions. After reviewing that data, we set up a meeting with the four teachers, the school psychologist, and the principal to brainstorm why the compliance rate was so low. Several possibilities were generated, but no one was sure. At that point we decided to video tape one hour of each class and have a team of people review the tape to determine related factors. The team consisted of the four teachers, the psychologist, the principal, a special education teacher and a parent of one of the students with ADD. After reviewing the tape, it was clear that the manner in which directions were delivered was unclear many times and we, as teachers, needed to adopt a more consistent approach to giving instructions to the class. The parent on our team had been involved in a training program where Forehand and McMahan's work was used. That material was shared with the teaching staff and the staff agreed it seemed to be a reasonable approach to improve direction following among first graders. No special material was needed but the four teachers needed to be trained in the system. Comprehensive Care had conducted the parent training program, thus they were contacted and agreed to provide the training to the four teachers in two , three hour training sessions. It was also requested that each teacher purchase a copy of the text that explains the process, Helping the Noncompliant Child.

- Training
- Material

•How to Implement

The program consists of a specific mannner in which to give children directions and how to follow up if they do not comply. Every direction given in the classroom should be specific and direct, given one at a time and followed by a wait of five seconds to give the child time to comply. A specific time out procedure is used if the child does not comply. Directions should never be vague, given in question form, be presented in sequence, presented with "let's" do this or that or preceded or followed by a rationale. After learning these techniques, our classes were again video taped. The method of giving instructions was rated and when we were all at 90% or above in using effective commands the program was ready to be implemented.

Each day for the next six weeks the four teachers used effective commands during the school day with all the children. This strategy was employed through out the school day except in activity classes, lunch time etc where the supervising faculty was not trained in the technique.

•Goals

The goals for the program were:

- Increase compliance to teacher instruction to 70% by the end of the six week period among children diagnosed as ADD.
- Increase compliance to teacher instruction to 85% by the end of the six week period among children without the diagnosis of ADD.

OUTCOMES:

•Impact

•Who Changed

•Evidence for Change

The impact this change in teacher behavior had upon the children's behavior was significant. At the end of the six-week period, the classes were again video taped. Teachers were rated as to their skill in using effective commands during those taped sessions. Each teacher had a 90% or higher rate of using effective commands. The children's rate of compliance to commands was also calculated. The children diagnosed as ADD had a 73% compliance rate and the children with no diagnosis had an 82% compliance rate based upon two thirty-minute video observations per day for a week . The goal was not reached but over a short period of time, significant change had occured in the manageability of class in the first grade.

REPLICATION:

•Setting

This program was used in first grade classrooms in an urban school of approximately 550 children. One would replicate the practice by becoming familiar with the techniques and strategies used in the Forehand and McMahan program and commit to implementing the program. It would be helpful to use support services as described above to gather data on teacher as well as student behavior.

•Other Settings

Even though this strategy was used with first graders, it seems appropriate with all elementary, middle and senior high school students. With older students, modifications may need to be considered in the manner time out is employed.

•Cost

There are no additional costs to implementing this strategy, other than cost of the text book and training if needed. It is felt that the strategies used to increase compliance could be self taught if concentrated attention would be given to the text and the teacher sought feedback on utilization of this skill by a peer.

APPENDIX E

E-1

Classroom Management Program

Student:

*	Time Period *						
* Date:	1	2	3	4	5	6	7
1. Remained in Seat							
2. Followed Instructions							
3. Paid Attention							
4. Raised Hand							
5. Stayed in Group							
6. Used Good Manners/ "Please & Thank-You"							
7. No Hitting/Aggression							

Classroom Management Program

Student:

RULES:

1. Behavior Chart is Marked Every Hour
2. Each Positive Mark is Valued at One Point
3. Feedback and *Lots of Praise* for Accomplishment are Given Every Hour
4. A *Brief* Explanation of "Non-positive Marks" is Given Every Hour
5. Points are "Tallied Up" at the End of the Day
6. Points are Exchanged Daily for Reinforcers from the Token Store Menu
7. Praise is Given Along with Rewards at Tally Up Time

Classroom Management Program

Student:

Token Rewards (30 points = 1 Chip)

1. Rewards: Cost 30+ points or 1 Chip
    - Pencil
    - Game with Teacher
    - Nobbie's Grab - cheap toy (ie 10-25 cents or less)
    - Sticker(s)
    - Happy-Gram to Bring Home
    - Art Supplies
    - Candy Bar
    - Potato Chips
    - Eraser
    - Etc.

2. Moderate Rewards: Cost 2 Chips or 60+ Points
    - Moderate Cost Nobbie's Toy (ie 25 to 50 cents)
    - Trip to Cafeteria
    - Larger Candy Bar
    - Etc.

3. High Value Rewards: Cost 3 Chips or 90+ Points
    - Trip to McDonalds
    - High Value Toy (ie $1.00 or more)
    - Special Award (eg Trophy for Good Behavior)
    - Lunch with Principal
    - Etc.

Jefferson County Public Schools

Daily Home Report

Name ______________________ Date ________

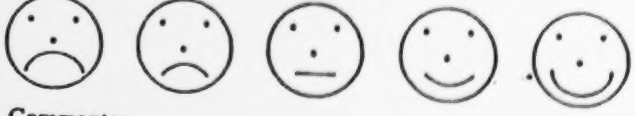
Behaviors **Ratings**

	M	T	W	Th	F
Did homework					
Completed chores					
Complied with requests					
Cooperated with parents					
Cooperated with siblings					
Helped					
Pleasant					

Performance Ratings

5 = Excellent
4 = Good
3 = Fair
2 = Poor
1 = Terrible/did not work

Child's Rating: Today, my behavior at home was



Comments:

Daily Student Report

Name ______________________ Date ________

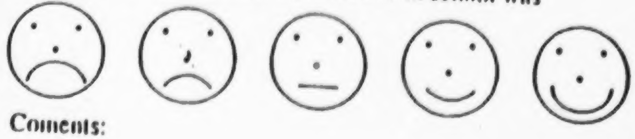
Behaviors **Classes**

Participated					
Initiated Assignments					
Completed Assignments					
Handed in home/classwork					
Followed classroom rules					
Interacted with peers					
Interacted with adults					
Teacher's initials/class					

Performance Ratings

5 = Excellent
4 = Good
3 = Fair
2 = Poor
1 = Terrible/did not work

Student's Rating: Today, my behavior in school was



Coments:

Jefferson County Public Schools

Goal Card Program
Grades One–Eight[1]

Child's Name ______________________ Teacher ______________________

Grade ______________________ School ______________________

Week of ______________________

Goal Card	Mon	Tue	Wed	Thu	Fri
1. Paid attention in class					
2. Completed work in class					
3. Completed homework					
4. Was well behaved					
5. Desk and notebook neat					
Totals					
Teacher's Initials					

Rating Scales

Check Scale To Be Used

N/A = Not Applicable
0 = Losing, Forgetting or Destroying Card

____	____
1 = Terrible	1 = Poor
2 = Poor	2 = Better
3 = Fair	3 = Good
4 = Good	
5 = Excellent	

Try for __________ Points

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[1] Adapted from: Harvey C. Parker, Ph.D. *The ADD Hyperactivity Workbook for Parents, Teachers, and Kids.*

ADHD BEHAVIOR OBSERVATION

Directions: 1. Target one other "average" child of the same sex in the classroom.
2. Alternate observing the referred child and the "average" child at 1-minute intervals. Observations should be 30 minutes.
3. On-task = +; off-task = 0.
4. Note any off-task behaviors or additional comments.

Name of Student ____________________ Date of Birth ______________ Age ____

School ____________________ Teacher ____________________

Observed by ____________________ Date of Observation ______________

Class Size ____________________ Time of Observation ______________

Class Observed ____________________ Length of Observation ______________

Describe the classroom setting and activity: ____________________

____

Interval	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total	Percentag
Referred Child On-Task																/ /15	
Other Child On-Task																/ /15	

Off-task behaviors (Referred Child): ____________________

____

____

____

____

____

Off-task behaviors (Other Child): ____________________

____

____

____

____

____

4691P-1 (3/12/92)

ADHD BEHAVIOR OBSERVATION

SUMMARY

On __________ (date), ________________ (student) was observed every ______ minutes for ______ minutes in his/her ________________ class by ________________________ (name), ________________ (position).

The class contained ______ (total number) students who were ____________________________ (activity).

In this setting, ________________ (student) was expected to ______________________________ ____.

A peer of the same sex was observed at the same time intervals to obtain a comparison of typical classroom behavior(s). ______________ (student) was on-task __________ % of the time. The peer was on-task __________ % of the time. ________________ (student)'s off-task behaviors included: ______________________________ ____ ____.

Additional notes: ____ ____.

Work samples collected prior to submitting this referral reveal ______________ ____ ____.

PHYSICIAN REFERRAL FORM

Student's Name______________________________DOB____________

Parent's Name______________________________Telephone_________

Address____

Referring School___________________________Date____________

The above named student is being referred for the following examination:

_____ Attention Deficit Hyperactivity Disorder

_____ Attention Deficit Disorder without Hyperactivity

_____ Other (Specify)

This student has been screened for ADHD/ADD without H by the School Psychologist and School Social Worker. A copy of the ADD Screening: Summary of Findings is attached. This report summarizes the findings from:

_____Review of Cum Folder/Report Cards

_____Standardized Testing Results

_____Conner's Scales (Home and Teacher)

_____Achenbach

_____Academic Performance Rating Scale

_____Others____

In order to coordinate the most appropriate classroom plan, we have enclosed a response form which indicates the status of this referral which we would ask you to return to us following your examination. A release of information has been signed by the parent and is attached. If you have any questions the contact person is the

School Psychologist____

Telephone____________________________

ADD REFERRAL STATUS FROM PHYSICIAN

Return to: School Psychologist______________________
School______________________
Address______________________

Student______________________Grade__________

Date of Referral______________________

STATUS:

_____Attention Deficit Hyperactivity Disorder Diagnosed

_____Attention Deficit Disorder without Hyperactivity Diagnosed

_____Medication Prescribed

Type:______________________

Dosage:______________________

Time:______________________

_____Medication Not Prescribed

_____Further Evaluation Needed

_____Follow-up Visit Scheduled

Date/Time:______________________

Referred To:______________________

_____Attention Deficit Disorder Not Diagnosed
No Further Medical Action To Be Taken

_____Other Diagnosis and Treatment Planned:______________________

____

____

____
Physician's Name

____
Date

ADD MEDICATION:FOLLOW-UP REPORT

Student________________________________Date____________

Parent's______________________________________

Teacher__________________________School Counselor____________

Physician______________________________________

Current Medication_____________________________Dosage____________

Time administered at school______________________________________

OBSERVATIONS:

Have you noticed or has the student complained of any of the following side effects?

How often/When

______Decreased appetite______________________________________
______Insomnia______________________________________
______Stomachaches______________________________________
______Headaches______________________________________
______Prone to crying______________________________________
______Tics/nervous movements______________________________________
______Dizziness______________________________________
______Drowsiness______________________________________
______Anxiety______________________________________
______Social withdrawal______________________________________
______Irritable______________________________________
______Sadness______________________________________
______Staring______________________________________

Have you noticed any fluctuations in behavior throughout the day? If so, describe.

Describe the student's attentiveness, (i.e. distractibility, listening, on-task behavior, concentration).

Describe the student's impulse control, (i.e. acting before thinking, shifting from one activity to another, supervision required, interrupting, awaiting turn).

Describe the student's physical activity level, (i.e. ability to sit still or remain seated, always on the go).

CURRENT ACADEMIC LEVELS:

_____Excellent _____Good _____Fair _____Poor

CURRENT PEER INTERACTIONS:

_____Excellent _____Good _____Fair _____Poor

OTHER CONCERNS:

Copy to: Physician
Parent
Cum

Revised 5/91

KENOSHA UNIFIED SCHOOL DISTRICT NO. 1
Attention Deficit Education Plan

Name: ______________________

School/Grade: ______________________

Date: ______________________

Review Date: June 19____ or at Time of Transfer ________

Teacher: ______________________

Counselor: ______________________

Participants in Development of ADEP:

____________ ____________ ____________ ____________

Currently on Medication: Yes ______ No ______ Physician ______________________

Type ____________ Dosage ____________ Times ____________

E-12

Behavioral Goal	Intervention and Teaching Strategies	Year End Review Comments

Original to Special Education Copy to Parent(s)/Guardian(s) Copy to Student Record

Anchorage, AK

STUDENT ASSISTANCE TEAM
INTERVENTION PLAN

STUDENT ________________ **GRADE** ____________
TEACHER ________________ **DATE** ____________

STEP 1. Cum File and Input Form include review-description of concerns/problems (4 min.)

____
____
____
____
____
____

STEP 2. Teacher's choice of one major concern/problem most in need of intervention (30 sec.)

____

STEP 3. Behavioral statement of desired goal (30 sec.)

____

STEP 4. Description of previous interventions used to address the major concern. (2 min.)

____
____
____
____
____

STEP 5. Brainstorm possible interventions (2 - 5 min.) (don't evaluate....limit to listing ideas.)

____
____
____
____
____
____
____

STEP 6. Teacher's choice of interventions to be tried (1 min.)

____
____
____
____

STEP 7. What obstacles may interfere with implementing the interventions? Which resources may be used to overcome obstacles? (4 min.)

- Obstacles	+ Resources

STEP 8. Using the information from Step #7, devise a plan of action which builds upon some of the resources to overcome obstacles. (5 min.)

PLAN OF ACTION

WHO	DOES WHAT	WHEN

Set a date to evaluate the plan's effectiveness in achieving the stated goal ________________________ (30 sec.)

STUDENT ASSISTANCE TEAM
PLAN EVALUATION AND MODIFICATION

STUDENT ____________________ **GRADE** ________________

TEACHER ____________________ **DATE** ________________

STEP 1. Teacher's rating of the effectiveness of the plan in reaching the stated goal (30 sec.)

1	2	3	4	5
Not effective		Somewhat effective		Very effective

STEP 2. Which intervention(s) worked? (2 min.)

____

____

____

STEP 3. Which intervention(s) did not work? (2 min.)

____

____

____

STEP 4. Modify the plan, building on interventions which were effective or develop another plan of action (5 min.)

PLAN OF ACTION

WHO	DOES WHAT	WHEN

Set a date to evaluate the plan's effectiveness in achieving the stated goal____________________. (30 sec.)

OBSERVATION OF ON & OFF TASK BEHAVIOR

Child's Name:

Date:

School:

Time of Observation:

Type of Activity Observed:

Subject

Peers of Same Sex
